the MODERN HOSPITAL

VOLUME 48 APRIL 1937 NUMBER 4

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For April, 1937

Just in Passing—

IN giving thirty-eight hospital "sit-down" strikers sentences of thirty days in jail, suspended during good behavior, Magistrate David L. Malbin of Brooklyn, N. Y., recently stated: "Persons engaged in hospital service must find other means of settling their labor disputes than by endangering the lives of the sick and distressed."

He went on to say that "no one denies that labor employed by private enterprise has the right to strike or picket to secure adequate compensation for their services or proper working conditions. The hospital, being in the category of a quasi-public institution, such an uprising against it can be likened to a revolt against a governmental agency."

THE necessity of finding "other means" of settling labor disputes in hospitals is even less important than finding means of preventing such disputes. It is with the thought of prevention uppermost that The MODERN HOSPITAL presents the leading article this month on a proposed labor policy for hospitals. The leading editorial also deals with this subject. Both of these should be discussed with hospital trustees and a constructive policy formulated.

FOR over two years the hospitals of the New York Metropolitan area have been engaged in an intensive self-survey. They wanted to know whether they were providing as much service as needed, whether they were providing the right service, how their services integrated with one another and with the other organized health services in the community and what plans to make for the future.

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CONTENTS

The survey was sponsored by the United Hospital Fund, directed by a committee under the chairmanship of Dr. George E. Vincent and made by a staff headed by Dr. Haven Emerson. Next month we shall present a summary of the conclusions from this important document. Many of the recommendations are applicable, with only minor modification, to any metropolitan community.

NATIONAL Hospital Day will be observed twice this year. In the United States it will, as usual, be observed on Florence Nightingale's birthday, May 12. In Canada, however, May 12 will be devoted to celebrating the coronation of a new king so National Hospital Day will be postponed one week. Next month we shall present a forecast of the program being prepared in one hospital.

THEY have been keeping clinical records quite a while at the New York Hospital. Next month they will celebrate in print the one-hundredth anniversary of record keeping. Some of the quaint old records are very interesting. Even more important is the development of the record department into a modern, efficient organization for the assistance of the physicians.

NURSES as well as physicians will find a great deal of interesting material in the article to be presented next month on the blood transfusion service at Cook County Hospital, Chicago. In simple straightforward fashion this article presents an effective technique for blood transfusions.

DO you have a hostess in your hospital? After reading the opinions to be presented next month on the value of such a person you may wish to give the matter serious consideration.

THE plant articles for May are especially valuable. They cover the air conditioning of a surgery at Touro Infirmary, New Orleans, safeguards that should be adopted by

A Summary of PROGRESS

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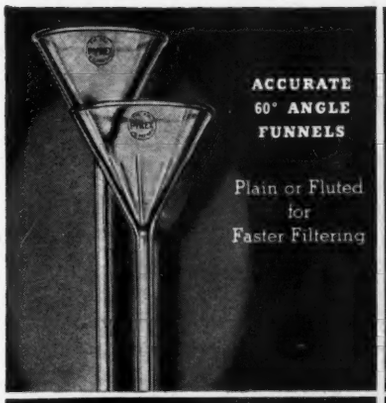

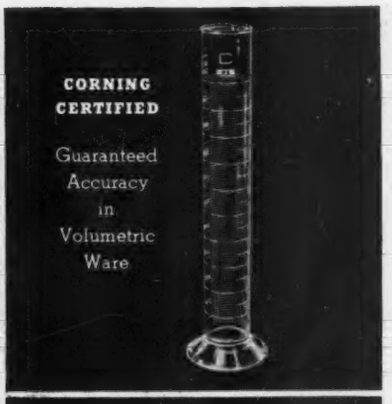

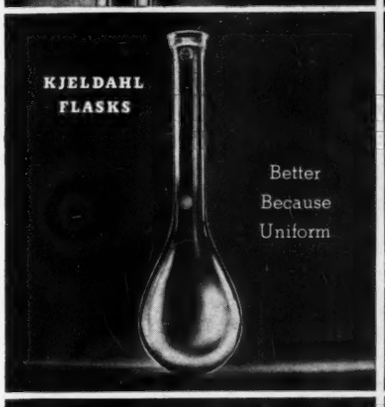

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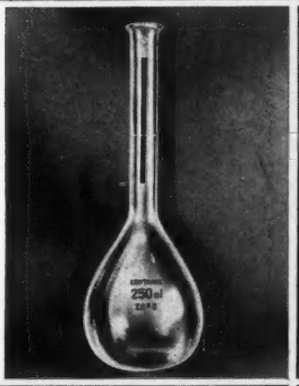


The Editor Talks It Over

• Have you ever noticed the long lists of hospitals which some manufacturers publish as using their particular product? Just what does this type of advertising mean? Is one to infer that an institution is fully equipped with a particular brand of sterilizer, rubber glove, hemostat, blood pressure apparatus or linen when its name appears on such a list? The cynic might suspect that a piece of equipment has been donated to a large and representative hospital for the sake of adding its name to advertising propaganda. It would be fairer to prospective buyers if partial, trial or complete equipment could be designated by an appropriate legend on such advertising pages.

• A private room to be attractive to the clientele of a hospital must consist of more than four walls, one or more windows and the expected presence of a bed, a table and a chair. It must have something else in its equipment which for want of a better name may be called atmosphere. The attractiveness of a living room in an American home cannot be measured by the excellence of any one piece of furniture. The end sought is warmth, comfort—in short "hominess."

Bright rugs and curtains, chairs cheerful with chintz, inexpensive flowers from the institutional greenhouse, an attractive water container and glass, and the morning newspaper on the breakfast tray all assist in building home atmosphere in the hospital room.

Long after the patient has forgotten his preoperative fear, the uncomfortable semi-somnolence of the first two or three postoperative days and the pleasant period of convalescence, he will remember the little things which were done for his comfort. The first food, the visit of the occupational therapist, the attractive tray on a holiday, the simple flower with its greeting card from the hospital board of trustees, all will be found in the patient's book of remembrances.

A traveler on leaving Yosemite Lodge experienced this pleasure of which we speak in finding in his lunch box prepared by his former host a cordial good-bye message and a forget-me-not bunch of mountain flowers. Hospitals would do well to copy such inexpensive and yet highly appealing practices as are met by the tourist here and there in this country.

• From the acme of distress and discomfort, from the fiery torment of a burning fever, from the very brink of threatened dissolution to the comfort and cool of beginning convalescence, this is the miracle of the crisis of lobar pneumonia. No disease is more dramatic in onset and decline, none more satisfactory in diagnosis and few offer a greater possibility for satisfactory specific therapeutic attack than this type of inflammation of the lung. Exhibiting a mortality which has been divided by two by the discoveries of the scientist, lobar pneumonia still continues as a menace to life, particularly for those in the third and fourth decades. The hospital can offer much in the treatment of this disease if its equipment and personnel are adequate and if no time is lost on admission in inaugurating the use of serum or other medication.

• Wheel chairs and stretchers are pretty faithful hospital servants. To be sure, sometimes a rubber tire gets too large for the rim, and slips off, or buckles, and makes its distress known with an emphatic bump at every revolution. Sometimes the wheel bearings become loose, or broken or dry, and these servants then emit a high-pitched whine of pain. Perchance a nut that fastens the rear wheel to the frame becomes loose, and then it wobbles like the front wheels of a "flivver" in distress.

But tires may be reset for about fifty cents, and an inspection of our "rolling stock," with wrench and oil can, will save whines and squeaks, both on the part of the chair or stretcher, and the patients in or on them. Yes, a stitch in time saves nine, even in the case of a wheel chair.

• A nurse goes hurrying down the hall with an ice pack and quickly disappears into a private room. In the utility room another nurse is watching carefully over the sterilizer with one eye upon the gauge which always seems to register a steady steam pressure. Doctors are performing the never ending rite of "scrubbing-up" with the water at just the right degree of tepidity. Nurses peer at the room thermometers to ascertain the presence of a correct temperature. Over in the laundry the work goes ceaselessly on so that every day clean linen is available in all of the rooms and wards. The cooks in the kitchen are dependent upon the ice boxes for proper refrigeration and have come to rely upon them without further thought.

And down in the engine room is the man responsible for it all—the engineer. It is his job to see that ice plant, sterilizer steam, water temperature, room temperature, laundry steam and refrigeration function properly and it is no small task. A good engineer is priceless to the hospital.

• Genius often ripens early. Pasteur was thirty-five when he published his great work on ferments. Erlich was twenty-three when he began his research on cellular stains. Jenner was thirty when he first interested himself in vaccination against smallpox. Lavoisier was thirty-two when he discovered oxygen. Widal was thirty-four when he published his typhoid fever test. Long was twenty-seven when he performed the first operation with the patient under the influence of ether. Koch discovered the tubercle bacillus at the age of thirty-nine and Banting discovered insulin in 1923 at the age of thirty-one.

• A dignified laryngologist approaches the stretcher upon which a little girl of six awaits her turn in the tonsil clinic. "What are you doing here, my dear?" he asks. "What do you think," she replies, "I am going to have my picture taken." Out of the mouth of babes—

Looking Forward

Labor Policies

LAST month there was reported in this magazine, a study by the National Industrial Conference Board sounding a warning of a labor shortage by 1940. If present tendencies continue, manufacturing industries will soon begin to draw personnel from other occupations. Hospitals, of course, will not be immune.

It is vitally important, therefore, that attention be given as soon as possible to hospital personnel relations. Hence, The MODERN HOSPITAL is glad to publish in this issue Dr. E. M. Bluestone's informative and forward-looking article on a proposed labor policy for hospitals.

Independently The MODERN HOSPITAL has conducted a survey of opinion among hospital administrators. The results are strikingly similar to Doctor Bluestone's recommendations. In brief summary the following were the suggestions made.

1. Wages for hospital employment should be comparable to those paid for similar types of work by industry in the community. Employees should not be forced to contribute to the charitable work of the hospitals through their pay envelopes.

2. Wages should be paid entirely in cash when possible and maintenance and other perquisites eliminated.

3. Where maintenance must be provided to certain groups of employees, it should include well prepared, adequate meals attractively served, and sanitary, comfortable and reasonably spacious living quarters.

4. Hours of hospital labor should be comparable to those in industry and other activities in the community, roughly forty-four to forty-eight hours a week. No one suggests a forty-hour week for hospital employees. There are also obvious disadvantages to a legal prohibition of split shifts, as required in certain bills now pending in various state legislatures, disadvantages both to the hospital and to certain of the older employees. Hours of duty should be arranged, however, so that the employees' free time will be sufficiently long to be of value.

5. Hospitals should put greater emphasis on the competence of their employees. They should not be "asylums for the unfit." Pension plans should be inaugurated to care for deserving employees who no longer are efficient workers.

6. More attention should be given to training nonprofessional employees so that they may learn their work thoroughly and merit and receive promotion. Hospitals should realize that most employees now look to the hospital field as their life work.

7. Job analysis and job grading should be undertaken so that duties, hours and remuneration will be equitable between different individuals and between different classes of employees. (Note: A simple method of job grading adapted to hospital use is fully described and explained in the fourteenth edition of The HOSPITAL YEARBOOK). Hospitals should join hands to set up these standards for duties, hours, pay and perquisites.

8. Continued efforts should be made to cultivate the good will, cooperation and loyalty of the employees. Every employee should understand clearly that his problems will and do receive courteous, sympathetic and understanding audience from the department heads and the administrator. The board of trustees may well set up a special committee to consider and adopt principles for employee relationship in the hospital.

Sterile Catgut

In the *Journal of the American Medical Association* for February 27, 1937, appeared a report by the council on pharmacy and chemistry of that organization on its researches into the sterility of catgut.

This investigation was carried on under what were evidently carefully controlled and highly scientific conditions. Of the ability of John H. Brewer, the chemist, to carry on this important

investigation and to evaluate his findings there can be no doubt. Hence the conclusions drawn must be of interest to every hospital director and surgeon.

Meleney and Chatfield in 1931 described what they considered a satisfactory technique for testing the sterility of catgut. Clock, Brown and others have since contributed to this subject. Mr. Brewer's methods of study were meticulous and complicated and will not be given in detail here. He employed, with modification, the study technique of earlier investigators and his findings are both startling and disconcerting.

Of 1,020 tubes of catgut tested, representing the product of fourteen firms, thirty or 2.9 per cent were found unsterile as compared with the results of an earlier study when 12.5 per cent of specimens examined were found to be contaminated. Five of these firms no longer manufacture catgut. Four firms had placed their product on the market before the publication of Meleney and Chatfield's original paper.

It is of interest to note that micro-organisms were most often found in sutures in which chemical sterilization was attempted. Nevertheless, while the council on pharmacy points out the advisability of employing only catgut that depends on heat for sterility, it is evident that much improvement is being made in providing a sterile gut for use by hospital surgeons. It is also suggested that gut tubed before October 8, 1936, on which date the council's report was submitted to manufacturers, should be looked upon with suspicion.

There is nothing in this report which would tend to shake the confidence of surgeons and hospitals in the sterility of catgut generally. Hospital superintendents would do well, however, to heed the advice of this body, and to purchase surgical sutures of the highest grade, no matter what the expense.

Private Patients' Plight

ELSEWHERE in this issue is discussed the need for frequent scientific inventory of the hospital's work. The importance and difficulty of such a study must be apparent to all. Yet, the desire to protect the professional reputations of staff members while praiseworthy may become an absolute menace to the patient. Such surveys must be fair, impersonal and often frankly ruthless if the medical work of hospitals is to be kept at a high level.

The ward patient is fairly safe because he is treated by mature and well trained major staff physicians. No effort or expense is spared in his behalf. The private patient is often not so fortunate. Without the ability to decide as to the skill of his physician yet blindly believing in it, the pay patient is isolated from other contacts unless it pleases his medical attendant to call a consultant. He does not sense his danger and the true state of affairs may not even be known by his family. The physician, young and sensitized to the matter of convincing all of his own ability, considers calling for aid humiliating. The patient lives or dies with mature and often urgently needed help just without his door and yet he may not have the advantage of such aid.

Hospitals permit such a condition to exist because they argue that a pay patient possesses the right to choose his brand of medical treatment. And yet the board is legally bound not to permit untrained physicians to practice in the hospital even in the service of a private patient.

Staff consultations, free if necessary, should be required when private patients under the care of younger and less experienced physicians become critically ill. In the maternity department this regulation is more often found than in medical and surgical departments. To allow a physician, but one or two years in practice, to follow unguided a dangerously ill pneumonia or typhoid patient to recovery or death is unfair and wholly reprehensible. What has been called the private patient's plight is more than a myth.

Dr. William Alanson White

THE hospital field in general and mental hospitals in particular suffered a severe loss in the death on March 7 of Dr. William A. White, superintendent since 1903 of St. Elizabeth's Hospital, Washington, D. C. The loss to medical education and to medical literature is no less great.

Doctor White was distinguished on many counts: as administrator, consultant, educator and author. He is a past president of the American Psychoanalytic Association, the American Psychiatric Association, the American Psychopathological Association, the Society of Mental Hygiene of the District of Columbia, the International Congress on Mental Hygiene and of the governing board of the International Committee for Mental Hygiene. With all his honors, he never lost his simplicity.

His graciousness and generosity, coupled with his keen thinking, made him an outstanding member of the editorial board of The MODERN HOSPITAL. He will be greatly missed.

A Labor Program for Hospitals

By E. M. BLUESTONE, M.D.

Labor disputes sweep the land. Hospitals although vulnerable have been relatively undisturbed. Here is a program of preventive medicine to assure health in employer-employee relations

A PRIMARY qualification for employment in a hospital is a warm personality which will win the confidence of the patient, yet the precaution of engaging such people for service in hospitals is not always taken. Every applicant for service to the sick should be required to answer categorically and bear in mind forever after this question: "Are you naturally built for intelligent and sympathetic service to the sick?"

It is still held in some quarters that those who serve in hospitals occupy a position somewhere between full-paid workers in industry and volunteers working out of devotional motives, and should make sacrifices in salary because of the charitable nature of the enterprise. According to this point of view no employee may complain of being exploited, since he entered hospital service more or less out of philanthropic motives.

In difficult times this point of view is often responsible for economies at the expense of the working staff. Since the payroll is the largest single item of expenditure in the budget, it takes but one stroke of the pen to balance financial losses from any other source. This method of producing "economy" is defended to some extent on the ground that the employee serves the hospital partly as an act of charity, thereby enabling the hospital to maintain itself at lower costs than prevail in industry. The employee's contribution is thus increased at the expense of his income. In a situation like this the worker becomes a philanthropist in a double sense, since he renders philanthropic service at the bedside and also out of his pocket.

A study of working conditions in hospitals generally leads us to the conclusion that, with the exception of hospitals that are served by full-time volunteers working under devotional inspiration, all work done by the nonprofessional staff, where there are no other benefits to an employee, should be done on a full salaried basis. The philanthropic element in hospital work is obvious in the act of service to the sick and no further contribution should be required of the employee out of his salary.

A rapid survey made among a selected group of hospitals indicates, in the opinion of the governing authorities of those hospitals, that nonprofessional employees are paid noticeably less than they deserve for the work they are doing. For the benefit of the sick whom they serve, hospitals should secure the right type of employees and give them a reasonable income for their work. Such a change could and should be brought about without delay.

All hospitals should study their own labor situation carefully from this point of view, take counsel with each other as well as with the contributing public and the public authorities responsible for employment in public hospitals, and make whatever corrections may be found necessary. In some instances hospitals may borrow the best practices of industry.

The tendency, which has become disagreeably noticeable during the last year, to strike and threaten to strike against the interests of the sick, in order to enforce demands which may or may not be reasonable, must be condemned by public opinion, if not by the public authorities. The development of a finer sense of responsibility on the part of hospitals generally toward their workers may be noted with some satisfaction, and improvements will doubtless be made without the pernicious influence of the picket. In the hospital we deal with no stockholders, no commercial profits, no dividends and no merchandise other than human suffering which must be relieved largely by charity in its broadest sense.

While it is hoped that the grievances of hospital workers will shortly disappear as a result of a more enlightened attitude on the part of each side toward the other, we realize that differences of opinion will continue to exist, while efforts are being made to reduce them to a minimum. For

judicial purposes we have at our disposal the law of the land, the public authorities who control the disposition of tax funds, and the united philanthropic organizations, which are in better position to deal with controversial situations than hospitals are individually. In New York City, such organizations are the United Hospital Fund, the Catholic Charities and the Federation for the Support of Jewish Philanthropic Societies. No labor dispute need be solved at the expense of the patient, and this is bound to happen wherever strikers take the law into their own hands and disregard these three channels for redress. We must never forget that the hospital is represented by philanthropy on both sides, the employer being the trustee of philanthropic funds and the employee being credited with philanthropic motives that draw him to offer his services at the bedside of the patient.

Special Committees Are Needed

It is strongly recommended that hospitals generally create special committees on employment among their governing bodies to take sympathetic and continuous interest in problems relating to employment. Apart from any other consideration, this seems to be required by the fact that the pay roll is the largest single item of expenditure in the hospital.

Representing the board of governors on the one hand and the working staff on the other, the administration should be approachable and willing to concede the contribution of labor to hospital service. Individual employees should have ready access to their immediate superiors, as well as to the administration, for the discussion of reasonable complaints and, wherever this is the choice of the complaining employee, through a committee of his fellow workers within the organization and familiar with it. We have had reports from representative hospitals where this method has been adopted and are satisfied that this is the most workable.

When Hiring, Be Cautious

The qualifications of an applicant for employment in a hospital should be looked into with much greater care than is common at present. Confidential references should be furnished and accepted with the greatest care and with full regard for the interests of sister institutions. Wherever employees without specialized training are accepted for specialized work, such training should be provided and the salary of the worker adjusted accordingly. Hospital work being different in practically every phase, an educational program for employees should be prepared and the duties of each one carefully outlined and explained.

Labor turnover in hospitals generally is excessive and can be largely avoided by more careful attention to employee needs. This appears to be a chronic condition and unfortunately is too often accepted as a matter of course. The best interests of the sick obviously require the presence of a permanent, well tried and well trained personnel.

Sources of labor supply should be known in all their possibilities. Only responsible agencies which work honestly and cooperatively should be patronized, and candidates for employment should be free to forward their applications through any legitimate medium which they might choose. Selections must be made on merit only and with primary regard to the needs of the sick. Partiality or priority in any form should be condemned. Political considerations should never govern an appointment or interfere with the work of an employee.

From the outset, the exact duties of an employee should be clearly known, preferably put in writing. The hospital should stand ready to pay for extra work in accordance with a reasonable scale, and the worker should understand that hospital service may not always be of a routine nature and may call for extra work in emergencies for which he as well as the hospital should be prepared.

Let Employee Feel Secure

After a reasonable period of probation every worker should be given a sense of security in his position. This will vary according to the needs of the hospital and its service to the patients. Hospitals contract and expand in accordance with the needs of the community, and employees' schedules must take this phenomenon into account. At all times employees should give and receive a reasonable period of notice of resignation or discharge. In lieu of notice of discharge, a cash salary for the period should be paid, the notice period depending entirely on prevailing practices in industry which in instances like this hospitals should follow.

As far as possible, promotion should be made from the ranks and seniority should be recognized, except in instances where the requirements of the patient are such that newcomers to the working staff, and younger employees, are able because of experience, personality or for any other reason to render such service better.

The cash salary of an employee should be adjusted in accordance with prevailing economic conditions and without taking a discount for philanthropic service rendered. In making this adjustment the maintenance factor must be taken

into full consideration. We find a disposition on the part of many, mostly among employees themselves, to regard maintenance as an item which is "thrown in," without much extra cash outlay by the hospital. This point of view is faulty since maintenance has a definite cash value. However, maintenance should be furnished employees for reasons relating to the convenience of the patients, and not primarily for reasons of economy. Employees who may be needed for service in the hospital during the night and who for any other valid reason must sleep on the premises, should be housed by the hospital. An adequate cash equivalent should be allowed to all others, whose place of residence with respect to the location of the hospital should be taken into consideration in allotting the allowance.

What Maintenance Should Include

Maintenance, generally speaking, should include (a) a room, preferably single, but double only in those cases where the room is large and well ventilated; (b) at least three substantial meals a day, planned at a certain minimum, to which additions should be made for those who engage in heavy physical work (for employees who are given maintenance, all meals should be served in the dining room); (c) laundry of a reasonable quantity of personal linen; (d) incoming telephone service at all times, except during work hours when only emergency calls should be put through; (e) extra facilities in individual rooms such as radio outlets and bed lamps; (f) uniforms; (g) medical care over reasonable periods, in accordance with prevailing practices in industry. Ward beds, separation rooms, semiprivate rooms and private rooms should be made available for this purpose, depending on the rank of the employee and the availability of beds. Thorough physical examination should be made in every case of employment, and periodically thereafter, as indicated.

For employees not provided with full maintenance, it is advisable to serve lunch in the dining room of the hospital, if there are valid reasons for retaining the employee on the premises during the lunch hour. In other instances the cash salary should reflect a reasonable increase for the meal or meals through which the worker serves the hospital. The length of the meal period should follow prevailing practice in industry.

Salary scales should be adjusted from a minimum up, depending on education, ability, conscientiousness, loyalty, length of service, position held. It does not appear to be desirable in hospitals to follow a salary scale too closely, because of the differences in work that exist even in positions which appear to be similar. For such work as is done in the housekeeping, engineering, purchasing and accounting departments, salary scales may be borrowed from industry. In all other positions, however, hospitals will have to find reasonable levels after consulting with each other, as outlined above.

Employees should be paid at frequent intervals, preferably fortnightly and in the safest way for both sides, that is, by check, if these can be cashed without great inconvenience to the employee. A period of two weeks' sick leave and two weeks' vacation should be allowed, with pay, to all employees in the nonprofessional classification, after the completion of every year of service and at a time most convenient for them, subject to the needs of the hospital. Leaves of absence without pay should be granted at the discretion of the administration in deserving cases, provided the service can be adequately covered.

Hours of work per day should follow the lead of industry, but due allowance should be made for the needs of the patients. In a general way hospitals should, as far as possible, plan an eight-hour day for employees, but the fact should be recognized that in many instances these working hours cannot be consecutive without injury to the patients. One full day off a week should be the minimum. It follows from this that an adequate number of employees should always be on hand to serve the hospital. No one leaving the employ of the hospital, whether as a resignation or as a discharge, should depart without the so-called "exit interview" by a responsible officer of the administration. Only by personal contacts of this sort can we hope to achieve a contented and stable personnel.

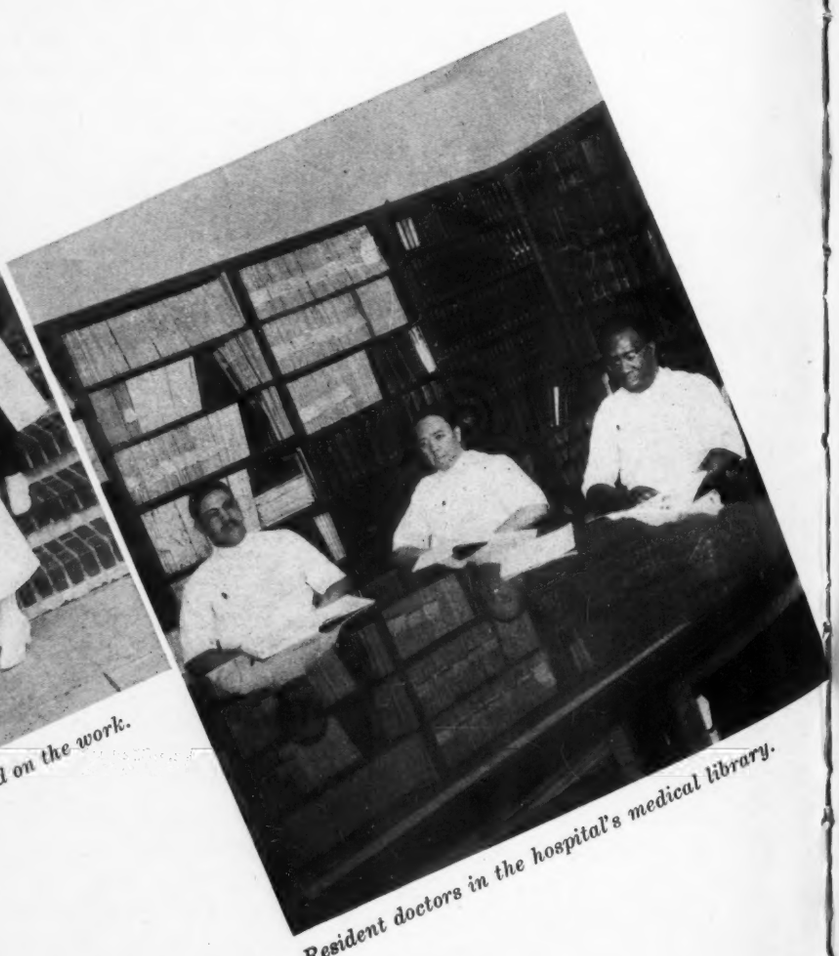
Social Security Benefits Essential

All of the benefits of the prevailing social security laws of this country should be given to hospital employees, regardless of the charitable character of hospital work, since only by providing reasonable insurance benefits against illness, old age, unemployment and death can we obtain the best service for our patients. Hospital employees should enjoy a corresponding and proportionate benefit of all increases in hospital income.

It is, indeed, desirable, in order to increase hospital income for this purpose, to stress the needs of hospital employees in appeals to the public for funds. It is important for the public to be aware of its partnership in the enterprise and to know that hospital expenditure must not be increased without an adequate financial quid pro quo. If the public wishes the payrolls of its hospitals increased, as it should be educated to wish, it must provide the wherewithal.

Flint-Goodridge Hospital—center of Negro health work in New Orleans.

Since 1934 graduate nurses have carried on the work.

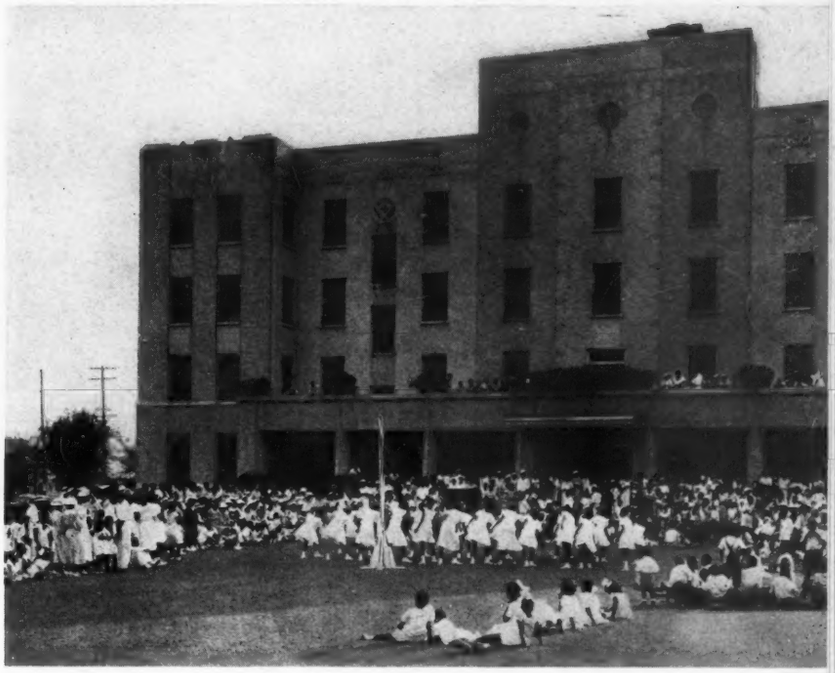


Resident doctors in the hospital's medical library.

Five Years of Negro Health Activities

By

RAYMOND P. SLOAN



Flint-Goodridge entertains! It is National Hospital Day.

IT IS unfair, perhaps, to apply the term "five-year plan" to this project started in New Orleans in 1932—a project designed to serve the health needs of the colored people of the city, also to provide facilities for training Negro doctors and other hospital personnel. Unfair, because the success of this particular plan leaves no room for doubt. Not only has it made its presence felt in the immediate community, but its influence in promoting better standards of Negro health and medical service has carried into other parts of the country, winning attention to the great need for such work.

It began when the coming of Dillard University made possible a brand new building, modernly equipped for Flint-Goodridge Hospital. The hospital itself was not new. Its history goes back fifty years to the time when a small group of colored women started dreaming of a place where members of their race could receive medical attention. Their dreams were realized. They called their hospital Phyllis Wheatley. After a few years New Orleans University took it over. Next it became known as the Sarah Goodridge Hospital, and finally as Flint-Goodridge.

It is an imposing businesslike structure today, containing one hundred beds. It stands on a corner in one of the colored neighborhoods of New Orleans, its rather severe modern lines softened by attractive landscaping. Winding paths in the rear lead to the laundry building and the nurses' home, and the walk to its out-patient department is well traveled. Day and night come men, women and children to seek physical relief and health guidance. The past five years have witnessed 81,179 such visits to clinics that originally numbered seven, but which have since grown to fifteen.

It is not so much what the building is, as what it stands for that commends it to attention—a community project to which Negroes and whites alike have given untiring effort that the death rate of Negroes in New Orleans, the highest of the major cities of the South, may be reduced, and that adequate training may be provided for Negro physicians. Also it remains an outstanding example of interracial cooperation.

This interracial cooperation is evidenced in the organization of its medical staff as established by the medical advisory board. An active staff of Negro doctors is aided by a consultant staff of white men whose names appear on the faculties of Tulane University and Louisiana State University. The consultant staff in turn comprises senior and junior consultants for each service, who serve as chiefs of various departments.

The junior consultants attend each meeting of their clinics three times a week. They work along with the various Negro physicians, and assume charge of the treatment of free patients admitted to their respective services in the wards. Each department holds a weekly staff meeting which is substantially a class in which the junior consultant assumes the rôle of instructor to the associated Negro physicians of the clinics, who as already explained, form the active staff. The junior consultants receive a small fee.

A Significant Plan

The significance of this arrangement cannot be overestimated. Colored and white physicians work together harmoniously with but one thought in mind—the welfare of the patient. Under this plan the Negro physician enjoys greater professional prestige, through working in close association with highly skilled doctors, and the white men, too, gain by personal contact and appreciation of competent Negro practitioners.

All the Negro physicians were appointed to the same rank in the beginning with the exception of one who even then was qualified to serve as chief of the surgical department. Therefore no junior consultant was appointed in that service, the white doctor being a consultant in the true sense of the word. The plan provides, however, for the eventual retirement of the junior consultants as members of the active staff develop to the point where they can qualify as chiefs.

"In addition to the instruction and experience available under our present plan of staff organization," explains A. W. Dent, superintendent, "we have found that it will be necessary for some of our active staff members to go away for concentrated study if they are to develop their abilities to the point where they can head departments. Toward this end we were able to secure a fellowship from the Julius Rosenwald Fund for a member of the department of eye, ear, nose and throat to do a year's study in London and Vienna. At the end of 1936 this man was elevated to the rank of chief of the department. It is our hope that each year we shall be able to provide a fellowship for study for one of our younger men.

"Opportunities have been given to twenty young graduates in medicine to serve internships and residencies. These men have come from Howard, Meharry, Western Reserve and Dalhousie Medical Schools. Toward the close of 1936 funds were granted by the Rosenwald Fund for the establishment of three residencies which will offer opportunities for concentrated work in (a) general medicine, (b) syphilis, (c) eye, ear, nose and throat."

Encouraged by its success in establishing better standards of medical and surgical procedure among its Negro doctors, the hospital went even further last summer when Mr. Dent was successful in getting funds to conduct a postgraduate course for physicians. This lasted two weeks, and instead of the twenty-five men who were expected to register, sixty-two in all spent the time taking advantage of the classes prepared for them. Other institutions cooperating with Flint-Goodridge were Louisiana State University Medical Center, Tulane University Medical School, Charity Hospital and Touro Infirmary. A breakdown of the enrollments shows 22 men from Texas, 14 from Louisiana (New Orleans—12, State—2), 8 from Arkansas, 8 from Mississippi, 6 from Alabama, 2 from Virginia, 1 from Kentucky and 1 from Kansas.

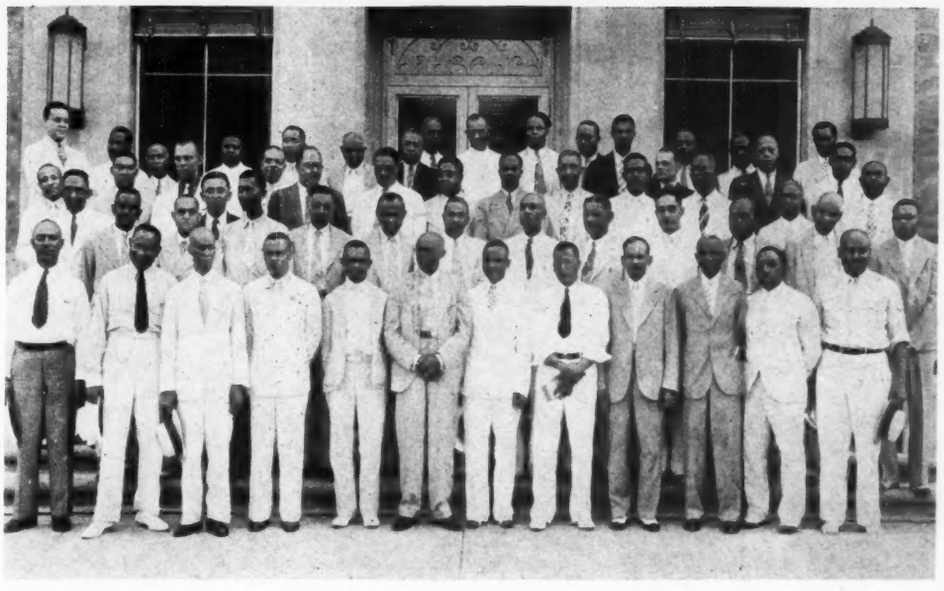
"The teachers were thrilled," says Mr. Dent. "Every single man met the class on time with the exception of one who was sick in bed. One of his associates came for him. The teachers presented themselves and their subject matter in such a manner as to make the Negro doctors like them very much. There was no indication of their 'talking down' to the men. The whole course was conducted on a very high level, and there was not a single embarrassing incident in the relationship with the individuals or the other institutions. The medical advisory board thinks the course is a good idea, and it is our hope that we may offer this type of educational opportunity to the Negro doctors in this section each summer as has been requested by those who attended last year."

High Standards in Force

The same high standards that have been established for the medical department at Flint-Goodridge apply throughout the institution. "It is our objective," Mr. Dent will tell you, "to have every person the very best individual that can be found for the purpose, to set high standards of excellence of performance for every class of work and to see to it that each person measures up fully to that standard."

Every department is headed by a professionally qualified person. When the hospital was first opened, for example, there was great difficulty in

Its fifteen different clinics are well patronized —81,179 visits during the past five years. In the lower picture appear some of the sixty-two doctors from eight different states who attended the postgraduate course held at the hospital last summer.



finding a qualified dietitian. There were three or four Negro hospital dietitians in the country, but they were all employed. A young woman was finally selected who had the academic background. Arrangements were made with Touro Infirmary for her to receive her practical training. In consequence Flint-Goodridge is taking several dietetic interns.

"We have been requested by Dr. Malcolm MacEachern of the American College of Surgeons," Mr. Dent adds, "to establish a brief course for medical record librarians. There have been several requests from persons wanting to take courses in laboratory and x-ray technique. We could, in fact, well afford to develop each of these courses to prepare persons for work, particularly in the smaller hospitals in the South."

We now have before us a thoroughly modern plant, well organized and manned with a trained personnel. What is it accomplishing? What of the health work that it is actually carrying on among the Negro population of New Orleans?

First, suppose we examine the figures. In 1936 the hospital served a total of 5,719 patients as compared with only 2,908 in 1932. Practically every ailment common to the community was represented.

It should be explained that the hospital's financial structure was predicated on the assumption that 20 per cent of the patients admitted would be free, and that there would be an average occupancy of 70 per cent. The earnings from these patients plus contributions from the New Orleans Community Chest and Dillard University would, it was felt, enable the institution to carry on without a deficit.

"During the last three years we have been able more nearly to predict our financial picture because of experience gained in the two previous years' operation," Mr. Dent points out. "We were therefore able to keep our expenses within our earnings. The uncollectable and doubtful accounts are written off only after the end of the second year, and they represent losses in earnings of the previous year. The percentage of earnings collected for the four years averages 8.5 per cent.

The net deficit for the five years ending December 31, 1936, was $8,261.96."

It is interesting to note that despite increased prices of foods and most supplies, the cost of rendering hospital service was reduced in 1936. The per capita cost after deducting costs of departments and services not chargeable to the care of bed patients was $3.19 in 1936 as compared with $3.96 in 1932. Average days of bed occupancy for free patients declined from 11 days in 1932 to 9.4 days in 1936. This in the interest of economy, because of the 50.8 per cent free service rendered.

During these five years the hospital's services have expanded steadily. It opened with seven outpatient clinics, for example. That first year a syphilis clinic and a surgical dressing clinic were added. Then in 1935 a well baby clinic was opened as well as a special diphtheria clinic and a diabetic clinic. In 1936 a tuberculosis clinic and a special eye clinic were started and only within the past few months a dental clinic has been equipped and is now in operation. It is hoped to organize a psychiatric clinic during 1937.

A fee of 25 cents was collected when possible from clinic patients until last August when this amount was reduced to 10 cents. This is made in no attempt to cover the cost, but rather to establish in the patient a sense of responsibility and self-reliance.

Social Diseases Attacked

In no phase of its health work among the Negroes has the hospital been more active than in combating the social disease problem. "During the 1931 study of the American Social Hygiene Association in New Orleans," according to Mr. Dent, "an inquiry revealed that at least 80 per cent of the colored men infected attempted either self-treatment or were treated over the drug store counter before going to a doctor or clinic. In order that we might in the simplest terms convey to the community the importance of protection against infection, early diagnosis, and adequate treatment, Flint-Goodridge Hospital in the fall of 1933 secured the cooperation of the American Social Hygiene Association who assigned to us a Negro member of its staff for six weeks. The United States Public Health Service also assigned to us a Negro member of its staff for six weeks.

"These two men along with the executive committee of the New Orleans Social Hygiene Committee and the hospital formulated a six weeks' program which included lectures on social hygiene, sex education and venereal disease control. These lectures were presented in schools and colleges, to faculty groups, to students above high school grade and to parent-teacher associations. In addition, fourteen moving picture showings were made in the evenings to adults in the city school buildings.

"A night institute for social workers and public health nurses was conducted and also a social hygiene training school for prospective lecturers. Various ministerial groups were consulted with a view toward their encouraging proper medical examination or treatment prior to marriage. Lectures on the significance and control of venereal diseases were given to employees in many industrial plants. During the six weeks' program, there was a total of ninety-nine meetings, the attendance at which was approximately 11,000.

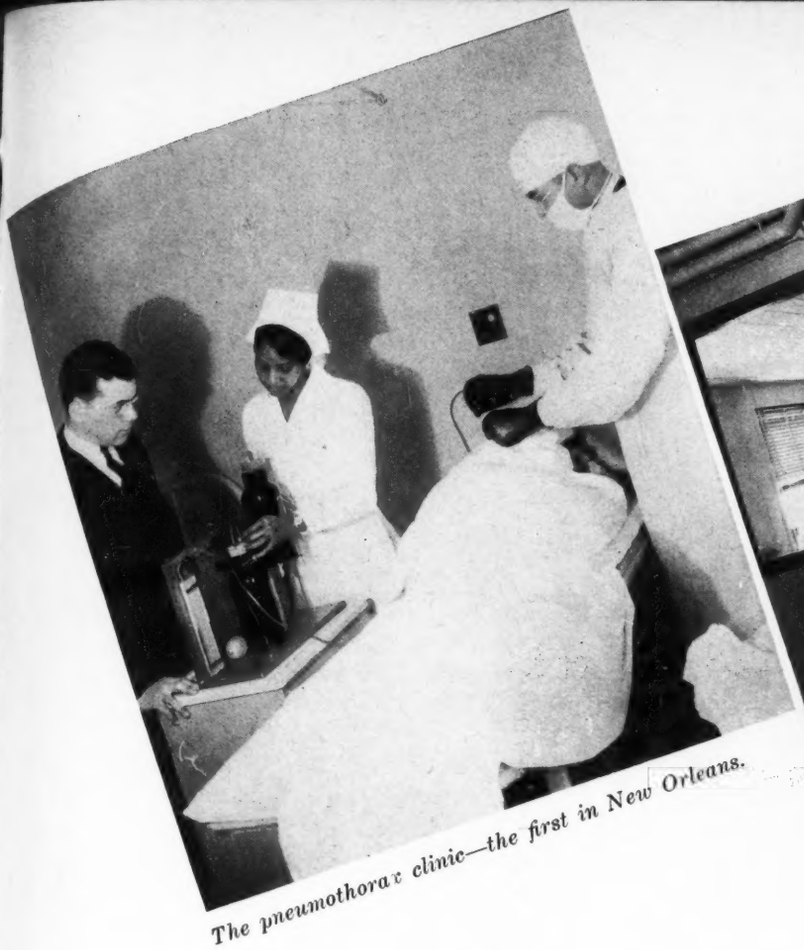
"As a procedure for sustained effort in venereal disease treatment and control, the hospital has continued to arrange for lectures to school groups, mothers' clubs and industrial employees. At the same time, we have set up in the department of medicine a special syphilis therapy clinic. Patients entering the clinics are given the Wassermann and Hinton blood tests. If there is any indication of syphilis, the person is immediately referred to this syphilis clinic which for all general purposes is known as Medicine B Clinic. All registrants to this clinic are interviewed by the social worker, and an immediate effort is made to bring in for examination and treatment if indicated all members of the patient's family. It would be futile to attempt the treatment of one patient in a family without treating the other members who are already infected and protecting those who are not yet infected.

This Medicine B Clinic was organized in the spring of 1934. Toward the end of that year we found that there were a number of persons who needed treatment for syphilis but whose earnings were too small to enable them to receive treatment from a private physician. To accommodate this type of patient, we established toward the end of 1934 a night clinic which meets on Monday and Thursday nights and is directed in the same manner as the other clinics. The attendance in this special clinic has constantly increased."

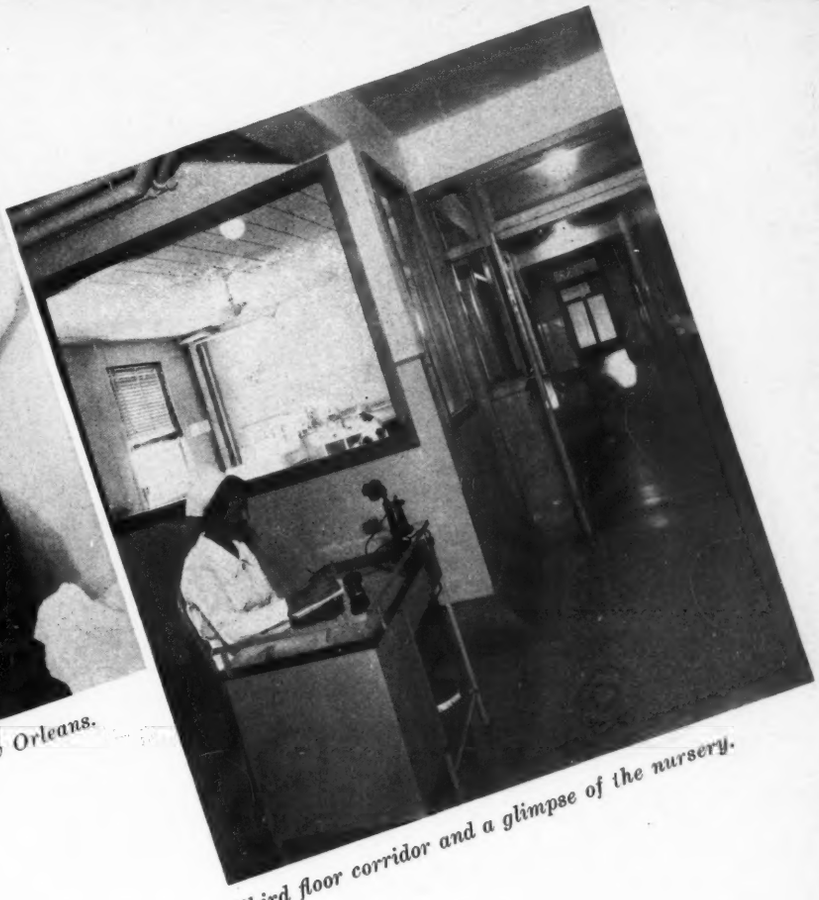
For Mothers

Another important part of the community health program centers upon maternity cases. Mr. Dent recites briefly the accomplishments during the five-year period:

"For the first six months of 1932, only fourteen babies were born in Flint-Goodridge Hospital. To determine where babies were being born, we secured from the board of health the place of birth of all babies from January through June of 1932. This information revealed that 25 per cent of all



The pneumothorax clinic—the first in New Orleans.



Third floor corridor and a glimpse of the nursery.

Negro babies were being delivered by midwives and that midwives were delivering ten times as many babies as the Negro doctors. We felt that the high mortality rates might be influenced by the lack of the presence of physicians during childbirth and accordingly assumed as a part of our responsibility to the community the matter of educating Negro women as to the necessity of proper medical care during childbirth.

"In order to demonstrate the effectiveness of educational work in this field, we secured the services of a social worker for a limited period. Furthermore, we reduced our rates to compare with those charged by midwives—$10 for a clinic patient, including eight days' care for mother and child; $15 for private patients for eight days. We even arranged this in installments so that when the woman was finally delivered her expenses were paid. Midwives were charging from $10 to $20.

"The social worker has been on our staff since 1933. It is her responsibility to organize mothers' clubs in various sections of the city, to teach the clinical obstetric registrants to keep their clinical appointments and to see to it that every baby born on the hospital wards returns to the well baby clinic once a month for one year for general observation and for instruction to the mother as to the proper care of her child. A recent survey indicated that approximately 72 per cent of the babies of free patients return to the clinic for this service.

"The mothers' clubs meet twice a month. The social worker usually meets with them. They are taught to make baby clothing, to embroider, to do basket weaving and hand painting. For the past two years the clubs have been conducting garden contests. At one meeting each month a speaker is arranged for by the social worker; usually a staff doctor, a hospital nurse and occasionally the hospital dietitian talks with a club about the proper preparation of wholesome but inexpensive and easily prepared foods.

"As a result of this activity the number of hospital births continues to make a striking increase. There is indication that the next step should be to establish a 'home delivery service,' making normal deliveries at home, where the home conditions warrant, as a matter of keeping hospital expenses at a minimum and of freeing the hospital space for abnormal cases."

Aside from these attacks on specific problems, many special efforts have been made to create an interest in general health information. The most important of these has been the annual National Negro Health Week conducted during April. A summary of one of these observances reveals that during the week approximately 100 health sermons were preached in churches, 70 lectures were

delivered in schools and public meetings to audiences estimated at 14,000, a radio address, the showing of health moving pictures to 3,000 school children, 116 health exhibits visited by 2,600, 120 pageants and plays with an attendance of 13,000, a health parade contest between the elementary schools, an essay contest in the high schools, the distribution of 15,000 pieces of health literature and the conducting of extra clinics at the hospital.

During each summer, Flint-Goodridge Hospital has been cooperating with a summer playground program, sponsored by the council of social agencies, by supplying physicians and nurses to speak to the children. During the summer of 1935 a motor corps of women was organized to bring girls in their teens from the playgrounds to the hospital where nurses lectured to them and gave demonstrations on the fundamentals of personal hygiene.

Diphtheria toxin was administered in 1935 to 1,508 children whose parents were unable to pay. One thousand one hundred and fifty-two FERA workers were examined in a special clinic to determine their ability to work on relief projects.

Realizing the effect of housing upon health, the hospital initiated the effort to secure a federal slum clearance project for the Negroes of New Orleans.

Another important development within the five years has been the formation of an exceedingly active women's auxiliary. There are now some 250 women divided into four units—educational, social service, beautification of plant and grounds and the sewing unit.

A Lecture Series Is Held

As part of the community educational program, women of New Orleans are invited at least once a year to a series of lectures on health held in the nurses' home of the hospital, sponsored by the auxiliary. These are held once each week beginning in April and cover such subjects as: tumors, especially fibroids, cancer; syphilis and gonorrhea, skin diseases; tuberculosis, high and low blood pressure; the eye, ear, nose and throat; immunizations, infections and contagious diseases; elimination, diet; care of the feet; care of the teeth. At least fifty women attend these lectures regularly.

Aside from the educational efforts among themselves and in the community, the auxiliary has contributed many hundreds of dollars for the beautification of the lawn, to the social service department for emergency relief to unusually worthy clinic patients, for Christmas and other seasonal parties for patients, and special articles needed by the hospital.

Any review of accomplishment at Flint-Goodridge would not be complete without some reference to the nursing service. The school of nursing inherited from the old hospital was discontinued in 1934. Since that time the work has been carried on by a staff of graduate nurses.

"We have not lessened our interest in the training of nurses, however," Mr. Dent emphasizes. "We realize that the hospital will not fully accomplish its aim until we are able to broaden our influence by sending forth a group of thoroughly trained nurses each year to meet the health needs of the community. We shall make every effort to reopen the school as soon as we have the required daily average of fifty patients and available funds for the adequate maintenance of the school."

Group Insurance Introduced

Finally, there is an accomplishment that can best be described in Mr. Dent's own words. It bears upon a subject which is of vital interest—group hospital insurance.

"In the fall of 1932 we entered into an agreement with the public school teachers of the city to furnish hospital service, when needed, for a fixed annual premium. A few months later we extended this type of service to a number of other employed groups. The services rendered under these agreements were in private and semiprivate rooms, and the premiums charged could hardly be paid by persons of the lower income groups. In order to reach the persons in the lower income levels, a plan was devised during 1936 whereby complete hospital service could be secured by groups of employed individuals for $3.65 a year —one cent a day. Many of these persons would probably come to us as free patients if some periodic group payment plan was not made available to them.

"Realizing that this small premium would support the plan only after we had secured a large volume of membership, an appeal was made to the Julius Rosenwald Fund for a subsidy until sufficient volume could be secured. Our request was granted, and in November we began the sale of contracts. There are now more than 700 subscribers. One man is employed exclusively on this project. It is our opinion that through the operation of this plan, the services of the hospital will be made available to more people and our earnings will be considerably increased."

So much for actual accomplishments during the last five years at Flint-Goodridge. As much additional space might be devoted to a discussion of plans for the future. That, however, is another story in itself—a tale of another five years of Negro health work.

Within the Law

Every superintendent should be familiar with certain legal aspects of hospital administration

By EARL WARREN

AN IMPORTANT question relating to the establishment of a hospital is whether the institution is to be established with a view to realizing profit or on a charitable basis. The determination of this question will have a legal effect upon every phase of hospital administration.

Within the past few years increased direct taxes and new indirect levies have added heavily to the cost of operating every business and institution, and the hospital is no exception. Unless organizers and founders of hospitals take into consideration the fact that in many states statutes exempt hospitals from general property taxation — and, in some states from corporation, income, inheritance and sales taxes — the institution may be unnecessarily financially handicapped.

Once it is decided whether the hospital is to be on a profit-making or on a charitable basis, the laws of various jurisdictions governing incorporation should be consulted, in order that the management may have the greatest possible latitude in directing its affairs, within the limits, of course, of safety to stockholders and the public.

In some states, before a hospital can be legally established, state or local authorities must be satisfied of the propriety of the site, the adequacy of equipment and the competency of the staff; upon a satisfactory showing, the necessary permit then issues. If the issue and sale of bonds, debentures, stock or other forms of securities are contemplated, it is essential under the provisions of the "blue sky" laws that a permit be obtained from the appropriate state authority approving such issue and sale.

In some parts of the country the gift or lending of public funds or credit to aid in establishing a hospital is legally possible. The possibility of such a subsidy applies particularly to charitable institutions, and care should be taken to see that the hospital is qualified under the law to be the recipient of public bounty.

As a matter of course, full and accurate records should be kept of all financial transactions.

Occasionally the collection of delinquent accounts is difficult. In this connection, the superintendent should have in mind that, under the statutes in various states setting forth the property exempt from attachment, garnishment or execution for debts of the owner, hospital bills may or may not come within a preferred class of obligations, for example, within the class of debts incurred for the "common necessaries of life," for the satisfaction of which the exempt property may be levied upon.

In adopting the plans for the physical equipment, care should be taken to conform to regulations of state and local governments with reference to minimum standards or prescribed types of building construction and the elimination of fire hazards.

It is of paramount importance to exercise care in the selection of the staff and employees of a hospital. Not only is this essential to the efficient operation of the institution, but a lack of care in selecting an employee may result in the imposition of liability for injuries to patients.

Under workmen's compensation and safety acts, various precautions must be adopted and appliances installed to minimize the possibility of injury to employees. For example, x-ray apparatus should be installed and operated with due regard to the safety of those who assist in its use. Elevators and other mechanical devices should at all times be kept in accordance with safety regulations. Failure to observe these safety requirements may mean liability for heavy damages for injuries, or material increase in premiums for workmen's compensation insurance.

Many hospitals maintain schools for the training of nurses. Under the state statutes not only are minimum standards set up for such schools, but living conditions and working hours of stu-

dents are regulated. At the present time, the Federal Social Security Act excepts charitable institutions from its provisions for pay roll deductions. If the hospital, however, operates on a profit-making basis, it may not take advantage of this exception. Furthermore, many states have enacted legislation providing for unemployment insurance, and it may be, in the jurisdiction where the hospital is located, institutions of the class to which it belongs may be required to contribute to an unemployment insurance fund.

The superintendent should have a thorough knowledge of regulations concerning records and statistics to be kept relative to patients. Failure to observe these regulations may result in civil liability, criminal prosecution or a damaged reputation.

A Recent Requirement

It is generally made the hospital's duty to keep a register of patients, to prepare vital statistics, to notify the proper authorities, in writing, of contagious diseases, abortions, the finding of abandoned children, and the treatment given injured employees. An additional duty of recent origin is the requirement that the hospital report the treatment of persons injured as a result of violence.

California has a statute typical of this responsibility, whereby it is made the duty of both the hospital and the attending physician treating any person suffering from any injury inflicted by his own act or by that of another, by means of a knife, gun, deadly weapon or in violation of any penal law, to report such fact immediately by telephone and then by mail to a designated law enforcement agency. Other statutes require the hospital to obtain a permit for every postmortem examination or the removal or disposition of a dead body, and a failure to secure it beforehand may cause those in charge of the institution considerable difficulty.

Another difficult problem of hospital management relates to the persons to whom these records and other charts may be shown. Constant requests are received for permission to inspect such data and attempts are frequently made to use the records in judicial proceedings. Only a few of the general rules of law applicable to such situations may be mentioned here.

The general rule seems to be that inspection may be denied to all persons, though in some jurisdictions by statute this right is given to a limited group. As to what records are admissible in a judicial proceeding, there is apparently a decided variance among the different states. In some jurisdictions by statute and in others by judicial decision, it has been held that a hospital chart or record is competent and admissible in evidence when the proper foundation is laid.

This rule requires that prior to its introduction in evidence it be established that the document is true and correct and was kept in the regular course of business, and that the entries were made by the nurse or physician in the performance of his duties or under the direction of the witness. In other jurisdictions, hospital charts or records are held inadmissible, the reasons being that the documents are hearsay or are a violation of the doctrine of privileged communications between physician and patient, which privilege can only be waived by the patient.

In addition to the legal aspect of the above problem, it must be constantly borne in mind that there are individual interests, each requiring separate consideration. The public authorities have certain rights in viewing the documents, as does the patient who has entrusted his care and treatment to the institution. On the other hand, the practice of allowing an indiscriminate inspection and use of the records may result in serious hardship, not only to the physician, the patient, and others connected with the institution, but also to the institution itself. Much of the difficulty in connection with records arises in civil suits wherein some person is seeking to impose liability upon the hospital, and because of the financial aspect the records create a problem of great importance.

Closed to Inspection

The superintendent should establish a policy of keeping records closed to inspection except by public officers in the discharge of their duties as such, by patients themselves and their physicians, and where by lawful process the records are required to be brought into court. Only by the strict observance of such a rule can the hospital avoid becoming the target of just criticism and being used as a source of obtaining business by ambulance chasers.

The majority of the actions brought against hospitals arise from injuries received by patients as the result of some alleged negligence on the part of the physician, nurse, intern or other employee of the hospital. In such cases the character of the institution, whether it be public, charitable or operated for profit, is of utmost importance, for different rules and measures of liability apply in the respective classes. In the absence of statute, strictly public institutions are generally not liable to a patient or a stranger for the negligence of their agents or for conditions existing upon the premises.

With respect to charitable hospitals, the weight of judicial opinion likewise relieves them from liability to the patient for injuries caused by their agents where reasonable care has been used in the selection and retention of the employee. As to their liability towards strangers or for unsafe conditions existing upon the premises, they are bound by the general rules of negligence.

Hospitals operated for a profit receive no immunity and are liable to patients, strangers or others as is any individual or corporation. In a "twilight zone" between these two types of institutions is the "industrial hospital," maintained wholly or partly by voluntary or involuntary contributions from the employees of a large corporation and admitting only such employees as patients.

The Question of Liability

The difficulty in determining when the institution is liable arises over the question of whether the hospital is charitable or operated for profit, and whether the negligent act was committed by an employee or by some other person, such as a physician or special nurse not an agent of the hospital at the time of the commission of the injury. This can probably be best illustrated by reciting the facts of an actual case.

A patient brought an action against a hospital for injuries due to a failure to remove sponges from the abdominal cavity upon the completion of a cesarean operation. The court first determined the character of the institution involved, and in doing so stated the propriety of looking not only to the articles of incorporation and by-laws, but also to the method of conducting the hospital. The patient paid regular rates, but the court found that the amounts paid were not used to build up a profit, but to assist in carrying on the general charitable purposes and concluded that it was a charitable institution. It then decided that there was no evidence to show that the hospital had failed to use due care in the selection of its nurses, and the institution itself was relieved from liability. Of course, such a decision does not relieve a negligent physician or nurse because all persons are accountable as individuals for their own negligence.

Had the hospital been operated for profit, an additional question would have been raised, namely, whether the physician or nurses were employees of the hospital or of the patient. While there is a division of opinion, many jurisdictions hold that though the head nurse and her assistants are general employees of the hospital, they are, nevertheless, during the time required for the operation, under the direction and supervision of the operating surgeon and are his servants, and for any negligence on their part in the performance of such service, the operating surgeon and not the hospital is liable.

Questions similar to those decided in the above case appear in most negligence cases involving the liability of the hospital, and the superintendent should have a knowledge of this problem based upon the law of his state.

Another important basis of liability presents itself when the hospital attempts to detain a patient forcibly. No one has the right to deprive another of his liberty without legal process authorizing his detention. It follows, therefore, that the management cannot forcibly detain a patient because of nonpayment of a bill. A few states have endeavored to protect the institution by making it a criminal offense for a person to defraud a hospital by receiving food and accommodation without paying therefor. Other states have given the hospital the right to detain a person where he voluntarily seeks treatment for intemperance or for a mental disorder. On the whole, the exceptions are few, and careful study should be made of legal requirements and responsibilities in connection with such cases, in order to avoid liability for damages for false imprisonment.

The superintendent and his staff should ever keep in mind that before an operation is performed the consent of the patient or his nearest relative or relatives should be obtained. In the case of a minor, such consent should be obtained from the parents or a legal guardian. The law recognizes the right of every person to keep his body inviolate from any kind of injury or mutilation, and this has repeatedly been held to penalize with damages the performance upon him of an operation without his consent.

Importance of Written Consent

In some states the general rule has been varied so as to allow the performance of an emergency operation necessary to save the patient's life when he was unconscious, and where his relatives, if any, could not be reached in time, but such statutes only serve to emphasize the advisability of obtaining written consent.

Care must also be taken to protect the hospital in connection with the custody of the body of a deceased person and the performance of postmortem examinations. It is uniformly the rule that the coroner or his jury has the right to the custody of a cadaver and the power to order an autopsy. Subject to this authority lodged in a public officer, the next of kin of the deceased are entitled to have the body delivered to them "in the same condition it was in when death super-

vened." Consequently the consent of the nearest relative of the decedent should be procured prior to a postmortem examination. The consent should, of course, be obtained from the relative who has the legal right to the custody of the cadaver and should be in writing.

Other legal problems arise in fixing responsibility for the payment for treatment furnished one who was brought to the hospital while unconscious; from the duty of the hospital to continue necessary treatment for a patient who, after his arrival in the institution, is discovered to be indigent or unable to pay for treatment, and the responsibility of hospitals under health insurance laws. These and many other kindred problems continually present themselves in every hospital and frequently require immediate solution by the superintendent without waiting to gather legal advice.

Subject to Inspection

Throughout the United States, hospitals are subject to inspection and varying degrees of supervision by public health authorities. Institutions which specialize in the care and treatment of specific classes of patients—maternity cases or those suffering from cancer, tuberculosis or contagious diseases—are frequently subject to further regulation designed to protect the lay patient from incompetency, inefficiency and various forms of quackery.

Moreover, the superintendent of the typical hospital is constantly reminded in other ways that his institution is not isolated but is part of a community of individuals. The modern hospital is usually located near the center of a residential district, and attacks are sometimes encountered on the part of real estate owners based upon the ground that the maintenance of the hospital in the neighborhood lowers the value of their properties.

It is universally held that when properly managed, the operation of a general hospital may not be thus enjoined, but sanitariums for the care of tuberculous and mental cases have on occasion been ordered by courts to vacate closely built-up and purely residential areas. In order to avoid injunction proceedings based on the allegation that his institution constitutes a nuisance, the superintendent must see to it that noxious and unpleasant odors are not allowed to escape in offensive quantities and that precautions are taken to prevent those living in the vicinity from being annoyed by screaming and other noises.

Mention has been made of questions of liability to patients for the negligence of members of the staff. There is another field of litigation in which the liability of a hospital, for the negligence of its employees even if it is not operated for profit, is much less restricted. I refer to liability toward strangers to the institution. As an example, in several states it is the law that a hospital is responsible in damages for injuries sustained on the highway by a stranger through the careless operation of its ambulance by an employee. This responsibility is generally recognized—even as to a charitable institution — when the hospital has agreed with the local authorities, for compensation, to have its ambulance respond to emergency police and fire calls. It is evident that the possibility of such liability must be considered in the purchase of insurance. Even slippery floors, which may be found in every hospital at some time in each day, may result in liability to some visitor.

Space has not permitted discussion of other important aspects of hospital administration, such as minimum hours of labor of employees and observance of pure food and drug laws, each with its own legal problems. Suffice it to say that the qualifications of the superintendent must extend far beyond the field of medicine. His status has reached that of a profession wherein the law, social welfare and business management each plays an equally important part, and for the superintendent to ignore that fact is to jeopardize the standing and future of himself as well as of his institution.

Advantages of a Central Supply Room

The term "central supply room" is synonymous with economy and efficiency. The hospital with a central supply room has all articles and equipment ready for immediate distribution and use, which eliminates waste of time or energy in the various wards and departments, and duplication. An order is sent through a tube conveyor and the supplies or treatment trays are sent down or up, as the case may be, on a dumb-waiter controlled by the central supply room.

There is a tremendous financial saving in that there is no need for departmental or ward equipment and maximum wear is obtained from every article whether it be an ice cap or a Luer syringe. It is efficient because of central standardization and supervision, and its definite placing of responsibility for preparation and maintenance of all medical and surgical supplies.

The training of the student nurse is efficient. She has experience during her elementary nursing period in the making and preparation of surgical dressings and during her advanced nursing period in the actual preparation as well as distribution of trays, solutions and sterilizations.

The only disadvantage might be the construction and plan of the hospital, for unless it was so constructed as to enable a central supply room to be efficient or economical, it would be most extravagant.—*Annie Crighton, R.N., superintendent of nurses, University Hospital, Baltimore.*

Palmprinting—As It Should Be

By GILBERT PALMER POND, M.D.

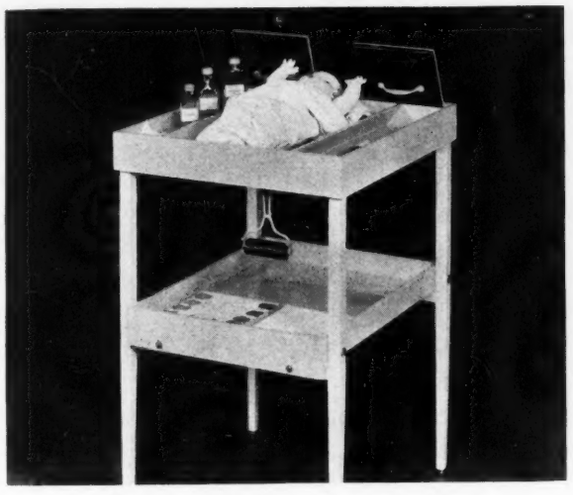


Fig. 1. Printing table and outfit.

THE theory of printing the palm is practically the same as any ordinary printing. In printing a book there are elevations (type) with spaces between. Ink is spread in a thin layer over the surface of the elevations and the paper is pressed against them. The ink on the surface of the elevations is thus transferred to the paper which has a greater absorptive power for the ink.

When the proper amount of ink is applied the marks on the paper are clear-cut and an exact mirrored or reversed duplicate of the shape of the elevations. If too little ink is used the whole letter is not printed, while if there is too much ink it fills up the spaces between the elevations and a badly smeared print results. The same general principles hold true in printing fingers or palms, but the work is much more delicate.

The technique of printing infant palms is comparatively simple but exact and great care must be used to make clear readable prints.

To be of any value prints must be made in the birth room as soon after birth as possible and certainly before either the infant or mother has been taken from the birth room or before any other infant or mother has been introduced into the birth room, that is, before there is the remotest possibility of mixing babies.

A print of the mother such as one or more fingerprints of each hand, made on the same card with the infant palmprints, enhances the value of the method by establishing a printed record of the maternal relationship between the infant and its mother. I have adopted a flat impression print of the index and middle fingers of both hands as most convenient.

The palm of the newborn infant must be prepared for printing because a clear print cannot be made when the palm is moist or wet or covered with vernix caseosa. If much vernix is present it is usually packed tightly into the valleys between the ridges leveling off the surface.

The surest and most simple method of removing the vernix is to wipe the infant palm firmly with a piece of dry gauze immediately after birth or before the vernix has dried by evaporation. This task can be delegated to the sterile nurse who assists the obstetrician. If, when the printing is done, it is found that some vernix is still interfering with clear printing a gauze sponge wet with hydrogen peroxide is used to wipe the palm. The peroxide will soften and lift out the vernix in most cases. If the vernix is so greasy that the peroxide will not permeate it, benzine will remove the fatty substance after which the peroxide will remove the vernix.

If the infant skin is waterlogged, having the appearance of adult hands soaked in dishwater, sponging with alcohol will dehydrate it, making the papillary ridges more sharply defined. None of these chemicals used in moderation is injurious to the infant skin.

For printing the infant palms any table of ordinary height will do, but in actual practice it has been found practicable to have a special cart which has a place for all the necessary equipment and a troughlike space for the baby. A cart such as this will save much time and many steps because it can be wheeled from one room to another fully equipped for printing anywhere. (Fig. 1).

The necessary material for printing palms consists of the following articles: a tube of printer's ink, an ink roller, an ink plate, a board for holding

Fig. 2. Method of holding the thumb.

the card on which the prints are made, print cards, gauze, a bottle each of hydrogen peroxide, benzine and alcohol, and a magnifying glass.

The type of ink that makes the best prints is a good grade of printer's or lithographer's black ink. This may be purchased in convenient sized tubes from any fingerprint supply house or any dealer handling inks put up for infant footprints. If the ink is too thick and sticky it is difficult to spread in a thin film on the ink plate and if it is too thin it does not remain on the tops of the ridges, but runs down the sides into the grooves between them. If it is too cold it is thick and should be slightly warmed.

The best ink roller is one made of a gelatin com-

Fig. 3. Ink plate turned upside down and impressed on baby's upturned hand.

position. It must be cleaned thoroughly after using before the ink has had time to dry and set on it. Benzine only should be used as any water or alcohol will spoil it instantly.

The ink plate may be easily made by any carpenter. Three-ply plywood cut to 6 by 6 inches is most convenient. To this is cemented a piece of double thick window or light plate glass. While the cement is drying the glass should be pressed firmly on the wood by weights. After the cement is thoroughly dry an ordinary loop screen door handle is screwed to the middle of the back of the board. A fine metal file should be used on the edges and corners of the glass to round the edges.

The board for holding the card should be of the same plywood, cut exactly 8 inches square. These dimensions are important and will be discussed in connection with the cards. A screen door handle is also screwed to the back of this board. It is of great assistance to cut notches on the edges of the back of the board exactly two inches apart, thus dividing each edge into four equal sections corresponding to the divisions on the card as described later. Both of the boards may be shellacked, varnished or painted as desired. The card is fastened to the board by rubber bands in such a position that they do not cover the parts where the prints are made.

The most appropriate size of card is 8 inches square because it allows just sufficient room for four infant palmprints on one side, two of each hand, and because 8 by 8 is the standard fingerprint card size and standard card files of that size may be purchased from any cabinet or file manufacturer, while files for any other size, except letter size which is larger than necessary, would have to be made to order which would add to the expense. For reasons given later it is best to file prints separately from the hospital record.

The card stock must be the best grade of fingerprint cardboard, hard pressed and smooth but unglazed. Rough paper will not record the fine ridges of the infant palm as unbroken lines and glazed paper does not absorb the ink readily hence it is easily smeared.

Two Prints Taken of Each Palm

Experience has shown that the best arrangement is to divide the left side of the card into four equal divisions of two inches square. These are for two prints of each palm. Two prints are taken of each palm so that if one is a little indistinct the second one may be clear in the indistinct part of the first. The two lower squares are for the prints of the left palm and the two upper for the right. The right side of the card is similarly blocked off and is used for subsequent prints if the first are not entirely clear or for check prints at the time of discharge of the infant.

The upper middle section of the card contains the classification bracket which was described in a previous article.[1] The bottom middle section contains two squares for the mother's left and right index and middle fingerprints. The central portion of the card contains the spaces for names, dates, numbers. Cards for male infants are printed in black, for female, in red. This difference in color of ink simplifies the search for an unknown by ruling out about half the prints at a glance.

[1]Pond, Gilbert Park, Identifying Infants, Mod. Hosp. 47: 67 (June) 1936.

The printing cart should be about the ordinary table height of 30 inches. Convenient dimensions for the top are 24 inches wide and 30 inches long. This should be in the form of a tray with ends and sides 2 inches high. The tray space is then divided by placing a 2-inch high partition, placed 2 inches in front of and parallel to the back wall. This forms a trough or compartment for holding the glass ink plate and board for holding the print card. Two more longitudinal portions also 2 inches high are placed each one 6 inches from and parallel to the sides. This makes a central trough, about 12 inches wide in which the infant is placed for printing, and a 6-inch trough on each side which are used for the bottles of cleaning fluid, the tube of ink and a supply of gauze.

A second tray should be placed about half way from the top tray to the floor. This tray is to hold the stock of print cards and any other material.

On the under side of the top tray near the front a screw hook should be placed on which is hung the ink roller. When not in actual process of rolling out the ink on the ink plate the roller should be kept suspended by the handle on the hook. This avoids smearing ink on the tray and also prevents flattening of the roller.

Everybody Ready

When all is in readiness for making a set of palmprints the infant is placed on its back in the center trough of the print cart with its feet toward the printer. The infant's palms are then cleaned and dried a second time, this having been first done by the sterile nurse immediately after birth as described above.

The ink plate is prepared by placing a small drop of ink about the size of a small pea on the glass. The ink is then rolled out into a smooth thin film with the roller. The roller should be drawn down over the glass many times then across allowing the roller to spin after each stroke. The ink film should be thin enough so that the grain of the wood may be seen through it. The roller is hung up and the inked plate stood on edge in the back trough of the cart ready to pick up.

The infant's left wrist is grasped by the operator's left hand and the operator slips his right index finger under the infant's curled fingers with his remaining fingers at the back of the infant's hand. The operator then approximates his index and middle fingers thus grasping the infant's fingers between them and at the same time the operator rotates his hand outward. This straightens out the infant's fingers and flattens its palm. The infant's thumb will still be flexed on the palm so the operator extends the thumb with his left hand and tucks it between the ends of his right middle and ring fingers. (Fig. 2). The infant's palm is now flat and free from obstruction ready for printing.

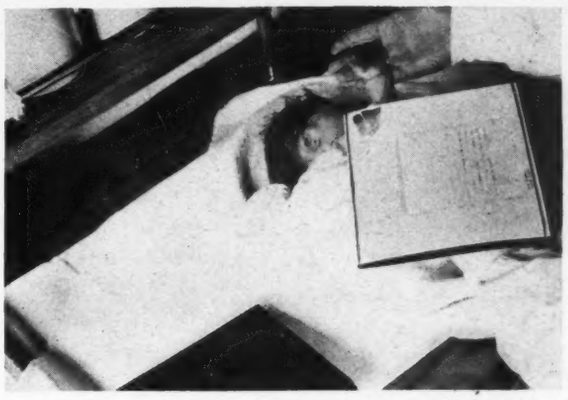


Fig. 4. This shows the finished product.

While holding the infant's palm open and steady the operator picks up the ink plate with his left hand and impresses it upon the upturned infant's palm. This impression should be made by a slightly rolling motion from the heel of the palm toward the fingers and the free edge of the ink plate should extend to about the middle of the infant's proximal phalanges. (Fig. 3). The ink plate is put down and the board with the card in place is picked up and impressed upon the inked palm in exactly the same manner. (Fig. 4). Before making the second print of the left palm the ink should be wiped off. The gauze moistened with peroxide will do this sufficiently. Usually it is best to get a new grip on the infant's hand for the second print.

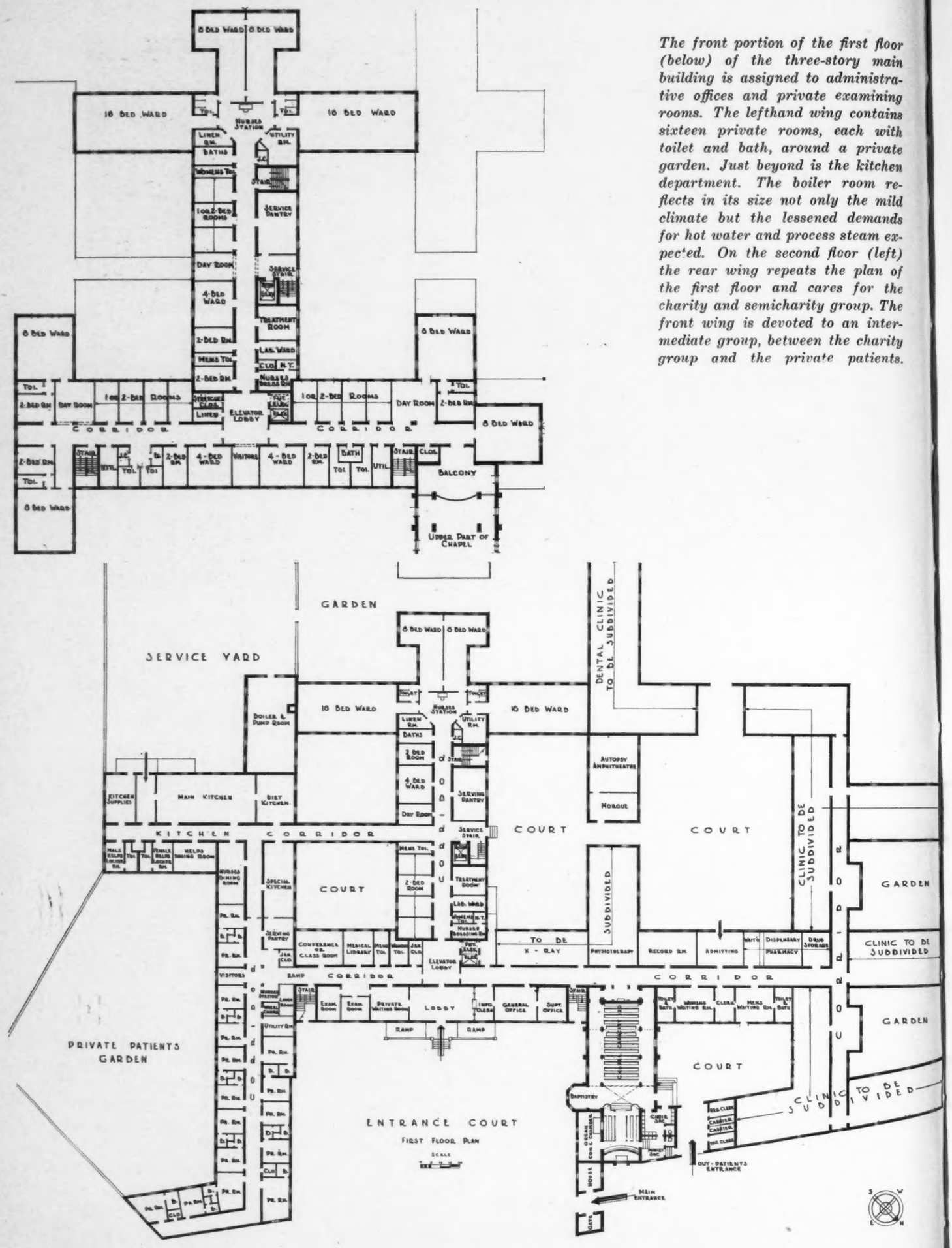
The printing of the infant's right palm is accomplished by the operator reversing hands for each move. This requires a little ambidexterity.

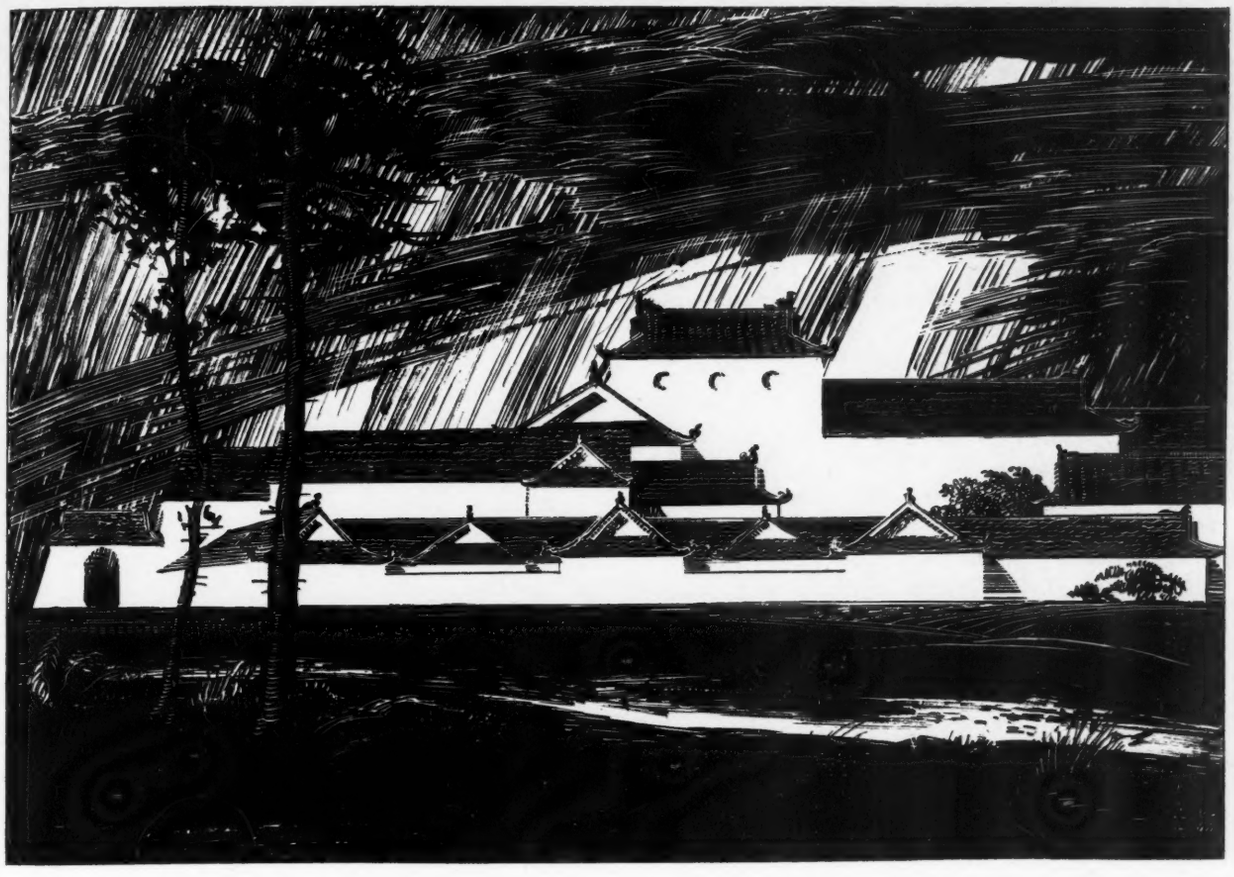
When the infant's prints are completed the mother's fingerprints are placed in the designated spaces and name, number and other data entered.

The classifying may be done at any time and must be done with the aid of a good lens. The best magnifier is the regular fingerprint outfit, but if this is deemed too expensive, a lens that is adequate is one called a "linen counter" which is much less expensive. For the details of the classification the reader is referred to the June, 1936, number of The MODERN HOSPITAL.

I strongly recommend the adoption of the proposed method of palmprint infant identification to all hospitals with an obstetric service whether they have used footprints in the past or not. Even if the hospital management feels that the classification is too technical or too much to do at present it would be far better to begin to print the palms now without classification instead of the feet, because experts have found them to be better adapted to identification purposes.

The front portion of the first floor (below) of the three-story main building is assigned to administrative offices and private examining rooms. The lefthand wing contains sixteen private rooms, each with toilet and bath, around a private garden. Just beyond is the kitchen department. The boiler room reflects in its size not only the mild climate but the lessened demands for hot water and process steam expected. On the second floor (left) the rear wing repeats the plan of the first floor and cares for the charity and semicharity group. The front wing is devoted to an intermediate group, between the charity group and the private patients.





Two Civilizations Meet

By JOSEPH BEECH, D.D.

IN NEW YORK CITY or in Chicago it would be just another hospital, but the modern clinical medical center being planned for Chengtu, a city in the extreme West of China, near the "roof of the world," is such a stupendous undertaking that its completion will indeed be the miracle it will seem to the hundred millions of Chinese, Tibetans and aboriginal peoples it will serve.

To the hopelessly inadequate personnel of the twenty mission hospitals in Western China, the completion of this project will bring promise of a hospitalization more commensurate with the district's great demand for medical care. To the teachers and clinical staffs of the West China Union University Medical Dental College, it will be the means by which they may continue the teaching of scientific medicine and present day surgery in this area, 1,000 miles from the nearest medical college.

An adequate portrayal of the handicaps and discouragements encountered by teachers of modern medicine in hospitals of this character is difficult, but it is easily discerned that the finer and more sensitive the teacher, the more heavily these impediments weigh upon him. Denied a modern clinical hospital, the medical dental college would gradually move into the deepening shadows cast by outmoded and insanitary hospitals.

Let some well known doctor and teacher of clinical medicine, who may read this article, sleep tonight on his magic carpet and awake twelve thousand miles away in one of our outmoded hospitals. He will find himself surrounded by students eager to learn modern medical practices. He may reach for a faucet, he may look for a radiator, but he will reach and look in vain. For running water, hot or cold, for heat and for sewage, he must rely upon coolies.

His first impulse will be to hop on the magic carpet and head for home. But if he has eyes to

see the multitudes suffering from all manner of diseases; if he has heart to feel for them; if he notes the rapidly increasing line of students hungry for knowledge, he will utter a hasty prayer for a modern clinical hospital and go to work, accomplishing wonders and surmounting difficulties by added devotion to his tasks.

Under such conditions has medical work in West China progressed since its beginning in 1892. In 1910 the West China Union University, with its faculties of arts, science, religion and education was founded by the foreign missions boards of the Methodist Episcopal Church and the Baptist Church of the United States, the Canadian Methodist, now the United Church of Canada, the Society of Friends and the church missionary society of the Anglican Church of Great Britain. Its medical school was organized in 1914 and the dental school a few years later.

In 1933 the university was registered with the National Government of China as a university, with colleges of arts, science, and medicine and dentistry. In 1934 the university was given an absolute charter by the board of regents of the University of the State of New York, with authority to confer the degree of doctor of medicine on graduates in medicine and doctor of dental surgery on the graduates in dentistry.

During this period of development, the medical and dental faculty increased from four to thirty-five, and medical and dental students from eight to 160 in number, 35 per cent of whom are women. This high percentage of women is a significant departure from precedent in the West and an entirely new movement in the Orient.

New Medical Center Will Rise

The growth of medical work conducted in the three mission hospitals and two dispensaries in Chengtu may be seen from the following: The full-time clinical staff consists of eleven foreign and thirteen Chinese doctors, assisted by a large group of residents, interns, clinicians and administrative personnel. There are six foreign and twenty-nine Chinese full-time graduate nurses and eighty-five student nurses. The hospital beds number 300; the yearly in-patients, 5,718; the out-patients, 71,334. The fees received average $166,-335, Chinese currency, over 97 per cent of all expenditure, exclusive of the salaries of the foreign staff contributed by missionary societies. These figures do not inciude the dental hospital, the university dispensary and dental infirmary, the midwifery school and clinic and the public health work, all integral parts of the medical and dental program.

Upon this foundation of staff, patients and income from fees, a new medical center of 500 beds and out-patient departments for 100,000 patients a year will be organized. Its purpose will be to bring the several classes of medical service togetner in one center; to provide for better medical treatment of patients and more effective cooperation in clinical instruction; to give to the college of medicine a clinical hospital adjacent to the college, designed for clinical instruction of a modern sort, and under its own direction; to more adequately accommodate the increasing numbers of patients, and, in coordination with other hospitals and agencies in the city, provide a complete medical service.

A Fine Testimonial

The volume of patronage and the amount of self-support we receive indicate the high place that Western medicine has won in Western China. Dr. A. Stampar, representative of the League of Nations to the National Health Administration of China, who visited West China last year, gives a fine testimonial in his critical report to the league and the Chinese Government, as follows:

"My conclusion, based on my visit and still more upon my impressions of its graduates whom I met at Chungking, is that the medical school is a good contribution to medical work in China. Its achievement is the more remarkable in view of the conditions under which it is working. It is self-supporting except for salaries of the foreign staff and for a small grant from the Ministry of Education. The university authorities, expecting help from the British Indemnity Funds, plan to establish a new clinical hospital; if this is carried through and the school were to receive a little extra assistance, both financial and technical, it could be suitably used as the main institution of medical education for the 100 millions of people living between Hankow and the Tibetan border."

Doctor Hume Reports

Dr. Edward H. Hume, formerly director of Yale-in-China Medical College and the Post-Graduate Hospital of New York City, reports to the China Foundation as follows:

"There has been built up in Szechwan, hitherto thought of as a remote and almost inaccessible province, a college of medicine and dentistry that ranks with the best in China. The Provincial Government might well give pause before setting up medical teaching and ask if a finer result could not be attained by concentrating on the medical dental college at Chengtu, making it serve as the provincial center for medical teaching by some form of cooperative arrangement."

The recently appointed provincial commissioner

of health for the province of Szechuan has recommended to the government a program of cooperation along the general lines suggested by Doctor Stampar and Doctor Hume, with dependence upon the college for the training of large numbers of doctors, dentists, nurses and public health workers for the province, with adequate government grants to cover the added expense.

This new hospital, at the uttermost part of the earth, will be more than buildings, it will be the logical outcome of the high altruism that marks the onward course of the ministry of healing in its nobler aspects. Proper buildings it must have, and the final word of this story tells how they come. When Generalissimo and Madame Chiang Kai-shek were in Chengtu they were asked to endorse our request to the British Indemnity Funds Trustees for $100,000. They replied, "We will do it." They did it by telegraph and letter to both the British Indemnity Funds Trustees and the China Foundation.

The China Foundation has granted us $25,000 (Chinese currency) and the British Indemnity Fund Trustees $75,000 (Chinese currency), and more is expected in future from these sources. This, plus gifts from an American friend of the project, has made it possible to secure authority to proceed with the foundations as soon as plans are approved.

Plans and specifications for this hospital have been under consideration by the medical dental college for nearly a decade. The results of those studies have been submitted to Schmidt, Garden & Erikson, architects, Chicago. The tentative plans and designs, drawn in harmony with the university architecture, together with descriptions by Carl A. Erikson, picture in intriguing fashion this modern hospital of our dreams.

The Building and Its Plan

By CARL A. ERIKSON

A TOLERABLY long pin, pushed into the earth at New Orleans, would emerge near Lhasa, the Forbidden City of Tibet, the home of the Dalai Lama, 600 miles west of Chengtu. Another pin, inserted at Philadelphia, would poke through Chinese earth north of Chengtu. In this area live a people who sometimes hear of a queer race living in these United States, who work while they sleep and sleep while they work. If they learn of our pride in irrigating systems they recall that Li Ping built an irrigating system for them 2,200 years ago that still irrigates a rich basin of 2,800 square miles. In the center of this basin lies Chengtu, a city of 600,000 persons.

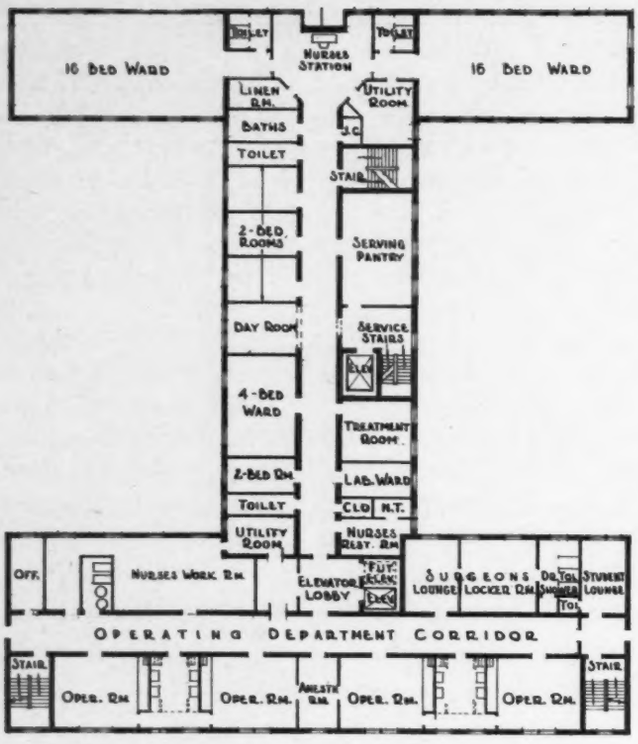
Only a few years ago it was a three-months' (1,500 miles) journey west of Shanghai via slow steamers and junks up the Yangtze-kiang to Chungking, then by shank's mare or coolie carried chair for 300 miles to Chengtu, the capital of the Province of the Four Rivers—Szechwan, with its population of 60,000,000, one-half of the total of the United States in one eighteenth of the area. Today's flying time is about seven hours.

Despite its remoteness from the sea the climate of Chengtu is not greatly different from that of New Orleans—few freezing days and summer temperatures not so high, but quite humid.

Chengtu knows little of many of our vaunted improvements. It has no municipal water system, so roofs, water carriers and the city's wells or one's own provide the limited supply. Sewage is too precious a fertilizer to be wasted; it is carefully collected and then distributed to the fields. Heating is a real luxury; a tiny charcoal brazier suffices for the aged and infirm in the most luxurious households. Electricity has only recently arrived, and it is hoped that within the next few years a railroad now under construction to Chungking will reach Chengtu so that it maf more readily tap the resources of the rest of the world. Lugging a boiler 300 miles from Chungking, the head of water transport, to Chengtu, over bad roads by coolie labor does have its difficulties, as does the long haul by junk.

No part of the building process is quite as simple as it is here. There are no contractors, no king will reach Chengtu so that it may more read- If one has the courage and faith to start building it must literally be from scratch.

Cement is far too expensive because of the transport so lime must be used, but it must first be burned. Lumber isn't to be had by reaching for the telephone. Here's the Chengtu alterna-



The front wing of the third floor contains the four operating rooms, each with a student gallery (reached from the attic), and usual accessories. The small number of operating rooms promises to be satisfactory because of the limited number of surgeons on this full-time staff. Sterilizers are expensive in Chengtu so the bulk of the sterilization will take place in the nurses' workroom.

tive: find a man who knows the forests in the mountains; dispatch him with sufficient funds to buy the standing trees and engage a crew to cut them down and carry them to the river edge. Two springs later the logs arrive on the shores of the Min-Ho River. They are then carried by coolies to the building site.

Here is to be found none of the paraphernalia we associate with lumber processing. A large gang of coolies—two to a saw—rip the lumber into timbers, joists or boards as needed. For window frames, doors and other finished work the Chengtuans substitute hand tools for the power driven machinery of our huge planing mills and cabinet shops.

In this, the most ancient civilization of the world, Occidental medicine was introduced and found a ready acceptance. Patients are too numerous for the limited capacity of the few hospitals, and students too many for the facilities of the one medical school.

It is against this background that the West China Union University proposes to build a modern hospital of 250 beds initial capacity (future 500 to 600 beds) with an out-patient service that may grow to tremendous numbers. It is to be the teaching hospital of the medical school, supplanting two or three old buildings remote from the medical school.

Aside from racial and climatic differences this hospital differs in one important respect from most of those in this country. Its teachers are all full-time men, actively engaged in the practice of medicine. They not only care for the in-patients but for extensive groups of free and pay out-patients.

To those who confuse the modern hospital with some of its trappings—chromium plating, electric signals, colored tile, pneumatic tubes and other gadgets—Chengtu would be an impossible place in which to build. There isn't a single plumber in the town, but on the other hand labor costs only a few cents a day. Many devices and details whose extra cost here is amply justified are ruled out there. They would be many times as expensive there as they are here.

Even fireproof construction is ruled out—cement, steel or tile would be prohibitively expensive transported from Shanghai, Europe or America. It will be as fire-safe as it can be made with wood joists, bearing walls and intermediate cross walls of brick, fire stops in the floors and other fire preventive and resisting precautions.

Floors will be wood; there isn't anything else available except at prohibitive cost. Walls will be painted plaster. Doors will be paneled, not flush slab. There will be no steel trim in the building. It will be the first large building in Szechwan with a central heating system, hot and cold water supply and a sewage system. Electricity will be used in sterilization, but it will be confined to a very few places. At least one electric elevator will be installed for food and patient transport.

Every plumbing fixture, every foot of pipe and every electric motor must be laboriously carried into Chengtu from Shanghai or abroad. Even cheap coolie labor cannot carry a bathtub as cheaply as our American railroads. These few construction details are cited to illustrate how every single item of American hospital practice must be revalued at Chengtu.

The science of medicine recognizes no barriers of creed, color, or nationality. It is tempered by its art and transmitted by its practice to become the living thing that we know as the practice of medicine, varying widely from country to country, even from city to city.

The workshop of the practice of medicine, the hospital, will vary with that practice and necessarily with the customs of its people.

It might be argued that asepsis knows no coun-

try and that therefore a hospital with the hard sharp lines of a sterilizing machine, such as those proposed for Melbourne or Stockholm, would be equally appropriate at Chengtu. Perhaps, but wouldn't the psychologic trauma be considerable to a Chinaman, accustomed to walled-in gardens and courtyards, beautiful overhanging roofs and lovely textures, if, when sick, he was introduced to one of these ultra-modern medical factories? They are hard, and inhuman in any country; they would be more so against the old culture of Chengtu.

The other buildings of the university carry on the tradition of the Chinese, so we have tried to catch something of the spirit of Chinese architecture, both in the plan and in suggestions for the exterior. The Chinese building, no matter what its purpose, is arranged within walls and in closed compounds or courts. The buildings were increased in size by adding more courts, not by adding more stories. This essential of Chinese planning has been followed except that the central building is three stories high, flanked by two and one-story buildings.

The other outstanding characteristic of Chinese architecture is the overhanging roof so evident in the sketches. While architectural details have not yet been developed, it is hoped to follow the spirit but not the letter of fine Chinese architecture.

The site for the hospital is ample. Basements are not permitted, and the western exposure is bad for patients. The out-patients' section will be on the right with various clinics in one-story buildings that may be inexpensively enlarged to meet future needs. An unsual requirement is separate waiting rooms for men and women. Another, that many an American out-patient service will envy, is the bathroom adjacent to each out-patient waiting room. The x-ray and physiotherapy department separate the out-patient service and the main hospital. The chapel is so placed that it may be used without entering the hospital.

The front portion of the first floor of the three-story main building is assigned to administrative offices and private examining rooms. The lefthand wing contains sixteen private rooms, each with toilet and bath, around a private garden. Just beyond is the kitchen department, differing from American ones in two essentials — the main kitchen is much smaller, owing to the simple Chinese menu; there is in addition, a "special kitchen" intended primarily for the preparation of Occidental or other unusual diets.

The adjoining boiler room reflects in its size not only the mild climate but the lessened demands for hot water and process steam expected.

The rear or central wing is practically identical for three floors. It is intended primarily for the charity and semicharity service in its two sixteen-bed wards, and two eight-bed wards, the one four-bed and five two-bed (or one-bed) wards.

War on Syphilis Through Persuasion

THE persuasive approach, as divorced from compulsion, is used by the clinic of the University of Pennsylvania Hospital in tracing contacts of syphilitic patients, according to Louise Brown Ingraham, Philadelphia, writing in the *Journal of the American Medical Association.* This method may be broken down into three accomplishments: identification of contacts; location of contacts, and persuasion of contacts.

The first interview of the patient with early syphilis is always preceded by a physician's examination and his discussion of the public health aspects of the disease. Clinic records show that if a short period of time elapses between the diagnosis and the first interview, the patient is more receptive to the social worker's suggestions.

The duty of the syphilitic patient to the community must be interpreted to him in a logical and convincing manner; a feeling of responsibility for warning others and preventing further suffering must be awakened, and he must be assured of his freedom from guilt in unwittingly exposing others. That the social worker who lays this groundwork will have a high proportion of patients willing to identify their contacts has been proved. Out of 201 patients questioned regarding their exposure, 114 gave information usable in contact tracing. These 114 resulted in 174 contacts.

The location of the contact is decided between the patient and the social worker, who agree which will take the initiative. Major emphasis is always placed upon the patient's direct appeal to his consort. The alternative is a visit by the social worker made with the approval and permission of the patient. Addresses and identifications of out of town contacts are referred to health officers elsewhere with the permission of the patient. When the patient is willing to locate his contact, he is offered the facilities of the clinic for the contact and given an admission ticket for him.

What Others Are Doing

Sunday Health Talks Popular at Faulkner

The second season of Sunday afternoon health talks at The Faulkner Hospital, Jamaica Plain, Boston, is meeting with growing response on the part of the public. "In fact our chief worry," Frances C. Ladd, superintendent, reports, "is where we shall seat the overflow audience each Sunday. Each subject presented seems to have its own interest and all lectures have been well planned by the speaker in advance. Lectures are accompanied by pictures, lantern slides and special equipment, all according to the requirements of that particular lecture."

The 1937 series opened with a description of the relation of the Faulkner Hospital to the district which it serves presented by Ingersoll Bowditch, treasurer. In the weeks following, members of the staff have discussed such subjects as "Diabetes: Its Cause and Treatment," "The Blood in Health and Disease," "Tumors: Benign and Malignant, Their Origin and Treatment," "The Care of Industrial Injuries and Medical Aspects of the Workmen's Compensation Act," "The Health Problem of the Growing Child," "Goitre: Its Symptoms and Treatment," "Laboratory Aids in Diagnosis and Treatment of Disease," "Surgical Diseases of the Kidney and Bladder," "Bone and Joint Deformities Following Injuries, with End Results of Treatment," "The Infantile Paralysis Problem," "Gall Bladder Disease: Its Diagnosis and Treatment."

The series started on January 3 and the last lecture takes place April 25, no meeting being planned for Easter Sunday.

This Hospital Went to the Fair

When Reading, Pa., held its fair, the Reading Hospital, West Reading, was represented by two exhibits, one, a two-bed room, the other a booth under its women's auxiliary.

Visitors to the two-bed room witnessed an actual treatment with the pressure suction therapy machine given to a bona fide patient in one of the beds. The operation and application of the ultraviolet ray was also demonstrated. Needless to say, everyone connected with the exhibit was plied with questions by onlookers. Judging by the crowds surrounding the display and the number of questions asked, the hospital feels the exhibit was well worth the effort expended to make it possible.

The women's auxiliary booth served as a meeting place for members and friends. Aprons, dolls, fancy work and various other articles made in the hospital's sewing room were on sale.

Broadcast for Babies

Friday may be just the day before pay day to most of the world, but to mothers of babies born at Mount Sinai Hospital, Philadelphia, it is the day that the Mount Sinai Babies Club of the Air broadcasts its program. Aunt Ethyl, who conducts the broadcast, reads off the birthdays of members that occur during the following week, announces new or renewed memberships, gives a short health talk and a nursery rhyme. The program comes on at 9:30 in the morning over station WDAS.

It Takes a Chock to Stop a Chair

Some chairs have a bad habit of not staying where they are put, particularly on the hospital roof. Even beds have been known to move slightly to the annoyance of the patient. The answer is a chock, according to Captain Harry H. Warfield of St. John's Riverside Hospital, Yonkers, N. Y.

This is nothing more nor less than a block of wood which slipped under the recalcitrant object may be depended upon to keep it in its proper place. Captain Warfield has them made in two sizes, about 36 inches and 48 inches long, in the hospital workshop, one for chairs and the other for beds. He bevels the edges, puts holes on either end so that they may be hung on the wall, paints them dark brown and labels them plainly "bed chock" or "chair chock." Convalescent patients take to the idea.

Schedule for Intern Service to Emergency Patients

When an emergency patient has been rushed to the hospital at a speed varying from fifty to seventy-five miles an hour nothing is more exasperating for him than to have to wait ten or fifteen minutes until the doctor comes to provide treatment. Yet when the doctor in charge of emergency service outside of regular clinic hours is merely "on call" he may be in his room in a distant part of the building.

To overcome this possibility the University of Iowa Hospitals have adopted a schedule for emergency service by senior interns. A room immediately adjacent to the out-patient entrance and just a few feet from the ambulance entrance has been fitted up with a bed, a radio and other conveniences. The intern assigned to the emergency service must stay in or near this room.

The schedule is drawn up for three months at a time and covers all the periods when regular clinics are not in session. The man on night duty serves from 5:30 p.m. to 8:00 a.m., the morning assignment on Sundays and holidays is from 8:00 a.m. to 12:30 p.m., and the afternoon assignment is from 12:30 to 5:30 p.m. At the University Hospitals there are enough senior interns so that the entire service for three months can be covered without calling on one man for more than six or seven times.

The intern assigned is considered the admission officer of the hospital during the period of assignment with full responsibility for handling the disposition of all patients presenting themselves for admission or service, it being understood that those patients requiring admission to the hospital shall be referred by the intern to the proper clinical service for admission according to his best judgment.

Those cases presenting acute conditions and requiring immediate surgery or major professional attention which the senior intern may not be prepared to handle in the admission department, are to be referred to the resident on the service involved.

Those cases requiring minor attention as out-patients are handled by the senior intern and disposition is made of the case according to his judgment.

Probably you can think of one or more practical ways to save time or increase efficiency. The Modern Hospital will welcome your ideas to put before other hospitals

Pooling for Protection

By ROBERT PENN, C.P.A. and ALLEN A. WARD

MANY hospitals receive a considerable portion of their income from unrestricted and restricted endowment funds. Such institutions frequently find that, in spite of careful investment policies and efficient methods of fund accounting, certain inconsistencies and inequalities exist as the result of allocating investments to specific endowment funds. This is often illustrated in the excessive accumulation or depletion of endowment funds through extraordinary profits and losses. One fund may benefit to the detriment of another simply because the trustees arbitrarily allocate certain investments to this or that fund.

This condition may be remedied by using the consolidated investment plan of pooling all marketable investments and by allocating to the purposes of the various funds a pro rata share of the income therefrom on the basis of the market value of the investments at the beginning of the period. Profits and losses from the sale of investments are allocated to the various funds on the same basis on which the income is apportioned.

The plan permits all endowment funds to share equitably in income and profits or losses of the consolidated investments.

The procedure necessary to put the plan into effect may require as a prerequisite the consent of the donors (or their legal representatives) of certain of the funds, the investments and cash of which have been consolidated.

At the date the plan is put into effect the records of the institution should of course show correctly the investments and cash of each fund and the corresponding liability account representing the net worth of the fund.

An example of a typical fund balance sheet before putting into effect such a plan is shown herewith.

Let us assume that the consolidated investment plan is to be started January 1, 1936, by the General Hospital, the fund balance sheet of which is shown at December 31, 1935.

The only entries to be inscribed on the books of the hospital are those showing the consolidation of the book values of the marketable investments of the endowment funds at the time of the inauguration of the plan. The entries do not change the book values of the investments or the net worth of the various funds.

The General Hospital in order to determine percentages for the allocation of income and profits or losses from endowment investments for the calendar year 1936 would prepare the statement of market values of investments shown on page 68.

The percentages shown are then used in allocating income and profits or losses from consolidated investments which would arise from the investments consolidated at December 31, 1935,

FUND BALANCE SHEET—DECEMBER 31, 1935

Assets			
Unrestricted endowment funds (at cost or gift values):			
Created by donors—			
Bonds	$ 23,500		
Stocks	14,850		
Cash	1,000		
		$ 39,350	
Created by order of the board of trustees—			
Bonds	$ 13,000		
Stocks	1,080		
Cash	500		
		14,580	
			$ 53,930
Restricted endowment funds (at cost or gift values):			
Fund A—			
Bonds	$ 9,200		
Stocks	10,300		
		$ 19,500	
Fund B—			
Bonds	$ 10,500		
Stocks	23,000		
Cash	250		
		33,750	
			53,250
			$107,180
Net Worth of Funds			
Unrestricted endowment funds—			
Created by donors		$ 39,350	
Created by order of the board of trustees		14,580	
			$ 53,930
Restricted endowment funds—			
Fund A		$ 19,500	
Fund B		33,750	
			53,250
			$107,180

and from investments purchased out of uninvested cash at December 31, 1935, or from proceeds from sales or maturities of investments which were consolidated December 31, 1935.

Endowments of cash and investments received during the calendar year, 1936, would not affect the allocated percentages as shown above. Income received from the investments of new endowments and profits or losses therefrom during the period from time of acquisition to the end of the first calendar year would be credited to the appropriate accounts and excluded from the income or profits or losses from the consolidated investments. Exceptions are sometimes made to this rule when large endowments are received in order to avoid the work of segregating income from these investments during the year. This is accomplished by recomputing market values and percentages.

For the ensuing calendar year, 1937, the General Hospital would prepare revised percentages as shown in the accompanying statements.

The statements show that the market values at December 31, 1936, of all securities together with cash amounted to $200,000. Of this amount 62.5 per cent represents market values and cash of endowment funds which were in existence at the beginning of the year 1936 and 37.5 per cent represents the market values and cash of endowment funds received during 1936.

Since the old securities have now been consolidated we know only the total market values and cash of this group which is 62.5 per cent of all market values and cash. Therefore, by applying this percentage to each of the percentages established at the start of the plan, we have the revised percentages of the old endowments. Adding these percentages of the old endowments to those of the new, we have the total percentages to be used in

MARKET VALUES OF ENDOWMENT INVESTMENTS PLUS UNINVESTED CASH AND PERCENTAGES OF EACH CLASS AT DECEMBER 31, 1935

	Unrestricted Endowments		*Restricted Endowments*		
	Created by Donors	*Created by Order Board of Trustees*	*Fund A*	*Fund B*	*Total*
Bonds	$ 21,000	$ 12,500	$ 8,000	$ 11,000	$ 52,500
Stocks	13,000	2,000	7,000	23,750	45,750
Uninvested Cash	1,000	500		250	1,750
	$ 35,000	$ 15,000	$ 15,000	$ 35,000	$100,000
Percentage	35	15	15	35	100

MARKET VALUES OF ENDOWMENT INVESTMENTS PLUS UNINVESTED CASH AT DECEMBER 31, 1936

		Percentages Dec. 31, 1936
Market values of endowment investments as obtained from market quotations plus uninvested cash at December 31, 1936	$200,000	
Representing:		
Market values of endowment investments plus uninvested cash belonging to endowments received during the calendar year 1936—		
Unrestricted—created by donors	$ 15,000	7.5
Unrestricted—created by trustees	25,000	12.5
Restricted—Fund C	35,000	17.5
Market values of endowment investments plus uninvested cash belonging to endowments in existence at December 31, 1935, consolidated as at that date	125,000	62.5
	$200,000	100.00

CALCULATIONS OF PERCENTAGES TO BE USED IN THE ALLOCATION OF ENDOWMENT INCOME AND PROFITS OR LOSSES FROM MARKETABLE SECURITIES DURING THE CALENDAR YEAR 1937

	A *Percentages Established at Dec. 31, 1935, for Year 1936*	*B* *62.5% of Column A*	*C* *Percentages of Endowment and Uninvested Cash Received During Year 1936*	*D* *Percentages to Be Used for Year 1937, Column B Plus Column C*
Unrestricted endowments:				
Created by donors	35	21.875	7.5	29.375
Created by order of the board of trustees	15	9.375	12.5	21.875
Restricted endowments:				
Fund A	15	9.375		9.375
Fund B	35	21.875		21.875
Fund C			17.5	17.500
	100	62.5	37.5	100.00

the allocation of income and profits or losses for the year 1937.

In connection with the plan and in the preparation of statements it is necessary each year to keep a record of new cash endowments and new endowment investments received during that year and also the uninvested cash in connection therewith. At the end of the year the cash and investments become consolidated.

Real estate investments or security investments having no known market values should be excluded from the consolidated plan and the income or profits or losses arising from principal should be taken up in the same manner as if the consolidated plan did not exist.

The advantages of the consolidated investment plan are briefly summarized as follows:

Maximum protection is afforded to the principal of any one fund against large losses and no one fund may be entirely depleted through unfortunate investments, since profits or losses are proportionately pooled.

Maximum protection is afforded to the income of any one fund since the plan permits an equitable proportionate allocation of all income. The plan allows long term planning for the expenditure of the income.

Eliminates the necessity for considerable bookkeeping in connection with the recording of investments and the income therefrom. Often one issue of securities is divided among many funds, resulting in much detailed recording of principal, income and profits or losses in one issue alone, which would be avoided in the investment plan.

Watch Those Storeroom Shelves

By O. J. SANDAAS

EVERY administrator would do well to ask himself this question: "Supposing my storeroom shelves were piled high with dollar bills and silver coin, instead of merchandise of almost every description, would I devise a better system of control?"

If the answer is in the affirmative, the chances are that his present methods are wholly inadequate. With intelligent purchasing, the supplies on our shelves do indeed become worthy representatives of the scarce and hard earned dollars with which they were bought—those dollars, incidentally, which receive such infinite care in their travels through our scrupulous accounting systems.

Fundamentally the duties of the storekeeper may be divided into three groups: (1) To count, weigh or measure supplies upon receipt and record the results on receiving slips which are subsequently sent to the accounting department. (2) To store supplies in designated places, new stock being stored back of old so that supplies will be used in order of purchase. (3) To issue supplies against requisitions bearing authorized signatures.

Constant supervision and regular inspections are the only remedies for ensuring proper storing, as outlined in the second group. Cooperation from dealers and a system of control without vexatious loopholes are imperative in matters concerning receipt and disbursement of supplies.

Rigid accounting for supplies is anticipated when purchase order forms contain a notice to vendors to the effect that bills and invoices are not to be enclosed or included with the merchandise but must be either mailed or delivered direct to the accounting department. In this manner storeroom clerks are forced to count, weigh or measure all merchandise received. Any inclination merely to copy quantities from invoices to receiving slips will be effectively discouraged. Temptations in the path of a storeroom clerk to appropriate any surplus quantities delivered are eliminated. Adjustments on books at inventory time are reduced.

With respect to the distribution of supplies, pertinent and definite regulations are even more important. We all know that supplies should be issued only against requisitions bearing the signature of an authorized person, and upon signed receipt of the employee obtaining the supplies.

Requisitions have sometimes been altered subsequent to being authorized, since it is possible for a storeroom clerk, or for an employee fetching supplies to change quantities or to add items in such a manner as to render the discovery of these malpractices difficult. For this reason it is recommended that requisition slips be made out in triplicate, the original to be sent to the storeroom, the duplicate to the accounting department and the triplicate to be retained by the department issuing the requisition for its own records. In the accounting department requisitions are not to be posted on perpetual inventory cards until an accurate comparison is made between original and duplicate.

The arches shown in the front view of the new preventorium enclose two recreation areas where children may play safely outdoors in inclement weather. Each loggia is 18 feet deep and almost half the length of the building. To the left is the light and airy washroom for girls, equipped with group washing fixtures, mirror, individual towel hooks and bench. The basement floor plan is reproduced on the opposite page.

An Ounce of Prevention . . .

By

H. ELDRIDGE HANNAFORD, A.I.A.

THE new preventorium building for undernourished and pretuberculous children is one of a group of thirteen structures comprising the entire Hamilton County Tuberculosis Sanatorium, Cincinnati.

In 1929 about $3,000,000 was allocated for a program of new construction at the sanatorium and the children's preventorium building was one of the new units scheduled. The development of the entire program was turned over to two associated architectural firms, Harry Hake, and Samuel Hannaford & Sons, to work with a building commission headed by Dr. Kennon Dunham, Cincinnati. Dr. A. C. Bachmeyer, then superintendent of the Hamilton County Tuberculosis Sanatorium and the Cincinnati General Hospital, served as consultant.

As the preventorium is a part of a group, certain units that are provided elsewhere have been omitted. Heat and high pressure steam are supplied from the central power plant; laundry work is done in a central laundry building; x-ray facilities are provided in a near-by infirmary unit, and classrooms and other educational facilities have been provided in a separate school building, southeast of the preventorium. Otherwise the building is complete in itself.

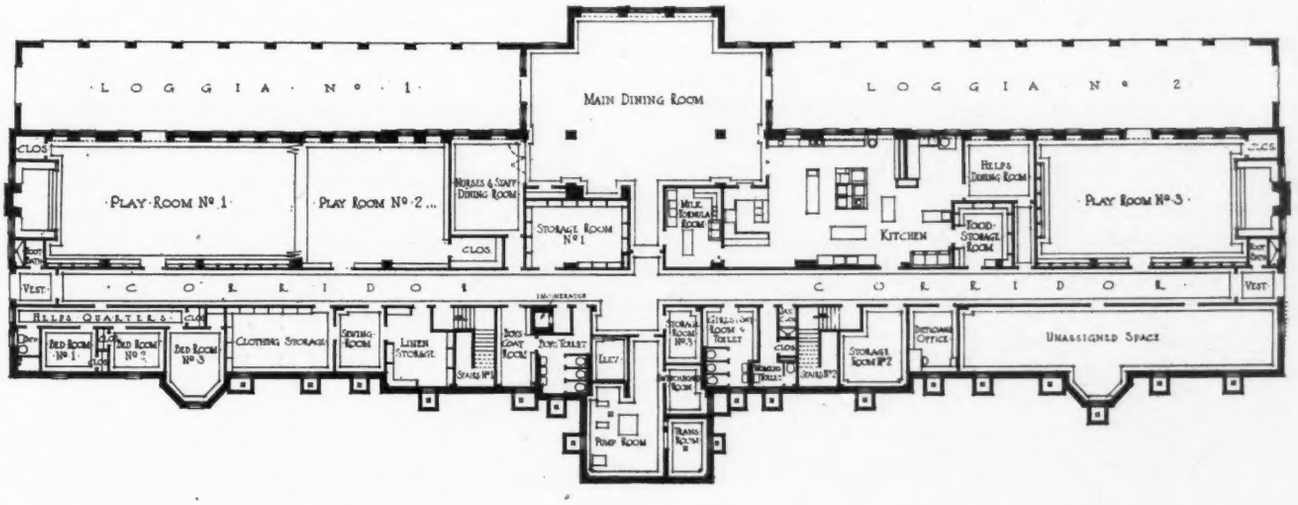
The preventorium, in a wooded grove near the northeast corner of the sanatorium's 125-acre plot, is about a quarter-mile from the adult patients' buildings.

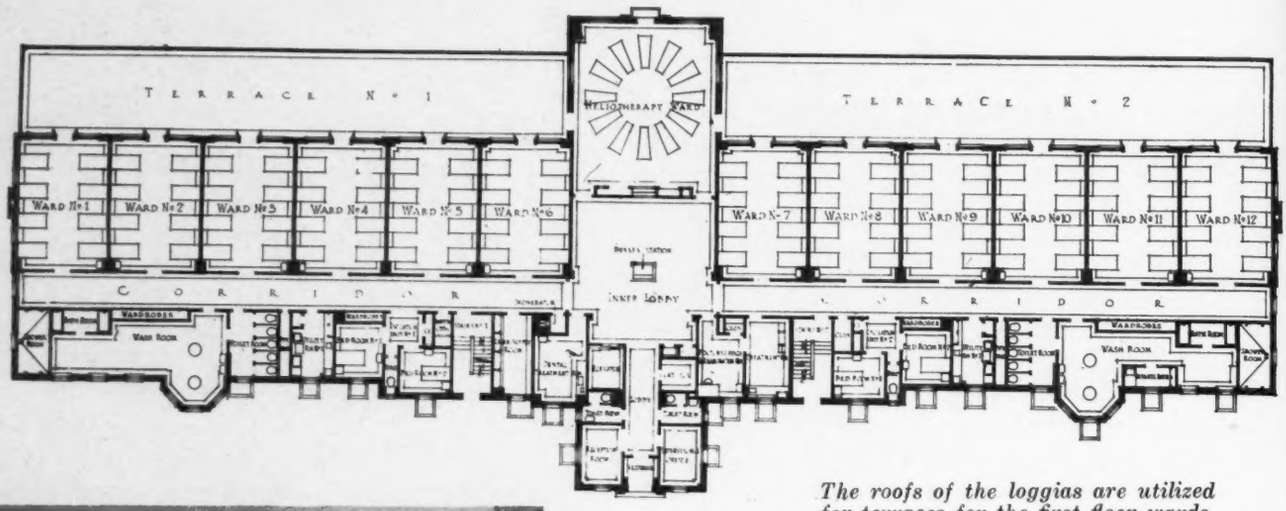
The building, which has a basement and first and second floors, faces slightly east of north, is rectangular in shape and measures 264½ feet in length by 50 feet in width, not including the loggias and center projecting bays. All patients' rooms and recreational areas are along the south face, the north face being used for offices, entrance lobby, baths, utility and other service units.

Because of the length and narrowness of the building and the fact that it would be occupied by children, the architects were permitted some freedom in exterior design and adopted an architectural treatment with a Spanish influence. Construction is of reenforced concrete, skeleton type, with enclosing walls of stuccoed masonry. The exterior walls are finished with a gray stucco while prominent openings are trimmed with stone. Roof surfaces are of brown and red mission tiles, with gutters and downspouts of copper.

The contour of the ground determined that the basement floor level be above grade, except for a small portion along the north center which is approximately 8 feet below grade. This permits sunlight to enter every habitable room sometime during the day.

A large portion of the basement is occupied by the three playrooms, two of which are arranged with faïence tile trimmed wood burning fireplaces and chimney nooks for story telling. Along the walls are placed hinged seats and wall cupboards to accommodate the children's toys. Open-





The roofs of the loggias are utilized for terraces for the first floor wards.

The dining room is large and friendly.

ing off each playroom is an 18-foot wide loggia extending practically one-half the length of the building. These spaces with smooth cement floors are used as open air recreation areas during inclement weather.

The culinary department occupies the south central section of the basement and consists of a splendidly equipped main kitchen, dishwashing space, food storage room, milk formula room, help's dining room, nurses' and staff's dining room and a main dining room large enough to accommodate all the children at any one time.

Through the longitudinal center of the building extends a 7-foot wide corridor with vestibuled exits at each end. Off each exit vestibule there is a 6-foot square area containing a foot bath arranged with a terrazzo water curb and wainscot and two shower heads set 24 inches above the floor, for the children's use in washing their muddy, bare feet before entering the corridor.

To the north of the basement corridor are the help's quarters consisting of three bedrooms and a bath; a large clothing storage space equipped with metal shelving; a sewing room for repairing linens and children's clothes; a large linen storage room equipped with five wood shelves; the dietitian's office; three large general storage rooms; the janitor's closet; women's and girls' coat and toilet rooms, each equipped with lavatories and water-closets, and a single juvenile closet for small children. Along the walls of each coatroom are wood seats with shoe compartments underneath and hook strips and hat shelves above.

Entrance Is at Grade Level

The approach to the first floor main entrance is at grade level. Through a tile wainscoted vestibule you enter an artistically decorated corridor, with a small reception room on the left and the supervisor's office on the right. Continuing through the short corridor you find lavatories for men and women visitors and a single large cloakroom. At the south end of the corridor is the information or nurses' station which is placed in the center of the inner lobby. To the left and right of the inner lobby are the ward wings for boys and girls, respectively, which accommodate 100 children.

The south side of the left wing is arranged with six glass enclosed eight-bed wards, which open on to an 18-foot wide cement terrace protected by a 3-foot high iron railing. Each ward is equipped with one pedestal lavatory, mirror and a hooded lamp, and at each bed is placed a double electric receptacle for hot pad and bedside lamp. The longitudinal corridor extending the full length of the building is 7 feet wide and has windows at either end.

For the storage of children's spare clothing, 50 lineal feet of deep wardrobes are provided in the

corridor, their ventilating grilled doors set flush with the face of the wall.

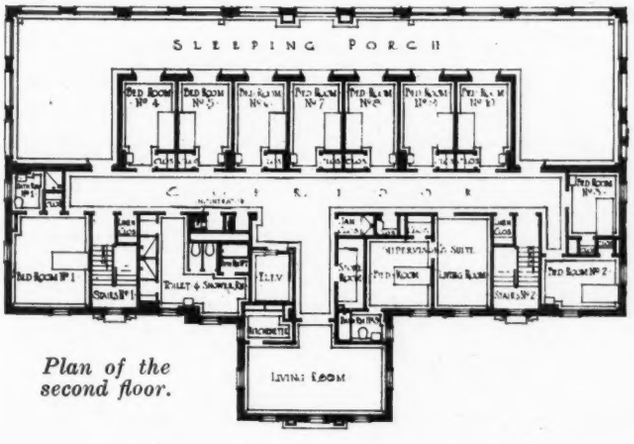
On the north side of the corridor (left wing) there is a dental treatment room equipped with operating chair, surgeons' lavatory, marble shelf and a metal case arranged with marble work counter, cupboards, drawers, plaster sink, aspirator, electric plug outlets, gas supply and instrument sterilizer. Adjoining the dental treatment room is a large linen supply room with 15-inch deep metal shelving on one wall while on the opposite are a large metal case with white metal work counter and sixteen cupboards with flush hinged doors.

The janitor's closet, adjoining the stairs, is constructed to accommodate mop trucks and is arranged with a terrazzo curbed floor trough, 4-feet high wainscots and a hose cock with 4 feet of armored rubber hose and nozzle. Along the back and side walls are open mesh wire shelves and hook strips for mops. The door to the closet has a ventilating grille.

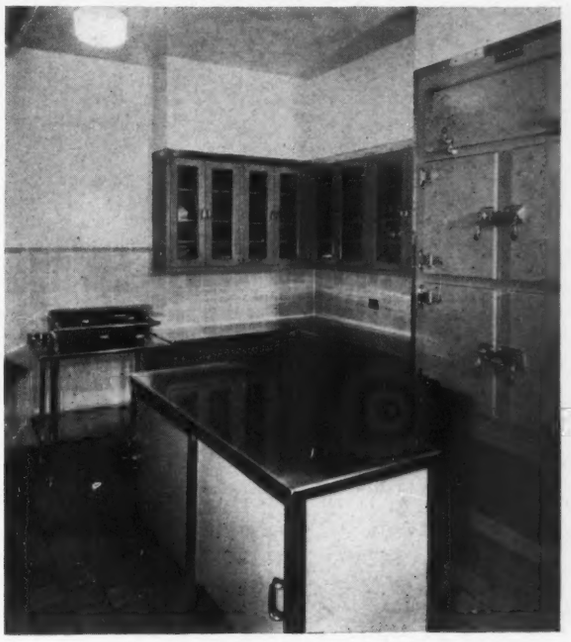
The isolation unit for the reception of new patients is arranged with a vestibule and gown closet, two private bedrooms and a small toilet room.

The utility room adjoining the isolation unit is conveniently located in the center of the block, approximately 55 feet distant from the farthest ward. Its equipment and arrangement are similar to utility units found in any hospital.

The ward toilet room in this wing is partitioned off from the washroom and is equipped with five wall-hung water-closets and one low water-closet for small children. Wall wainscot and closet enclosures are of marble. The adjacent congregate washroom which may be entered from the corridor or through a cased opening in the toilet room is arranged with two pedestal wall lavatories with a large mirror over, two circular foot operated wash fountains each accommodating six children, two 4-foot 6-inch built-in combination bathtubs and showers with one tub resting on a



Plan of the second floor.



A model milk formula room.

12-inch high base and a large enclosed shower space with four heads. A wide fixed seat extends along the north wall for the children's use while dressing.

The first floor wing, to the right of the inner lobby, is similar to the left wing previously described, except for a doctor's office, a treatment room and an infants' bath in washroom number 2.

The projecting bay back of the inner lobby, measuring 30 feet by 33½ feet, is used as a lamp treatment room for twelve patients. The space is equipped with a solarium unit and is completely air conditioned.

The second floor is solely for the use of the personnel and is planned with a large living room with an adjoining kitchenette for serving light lunches, a suite for the supervisor, one large bedroom with bath, nine single bedrooms for nurses, a large screened sleeping porch, linen and storage closets, janitor's closet and a large congregate toilet and shower room.

In general the floors in the basement playrooms and second floor bed and living rooms are of wood with terrazzo cove and base. Kitchen floors and accessory rooms are of quarry tile. All other floors are of rubber, tile or terrazzo. Where traffic occurs, wall corners have been metal protected and floor bases project from the wall to prevent plaster damage.

Ceilings of playrooms, dining rooms, utility rooms and corridors throughout are constructed with a sound absorbent material.

The building, which was completed in 1934, cost $205,300, including the bringing in of outside steam, water, sewer and electric services.

Clinics and Doctors

By PHYLLIS KATHRYN McCALMONT

IN RESPONSE to the complaints of Pittsburgh doctors that out-patient departments were taking away their patients, the Allegheny County Medical Society and the twenty-five clinics in the county introduced in May, 1933, the Pittsburgh dispensary plan. This is a modification of the Cleveland dispensary admission plan.[1]

Briefly the plan provides that all dispensaries will refer new patients who at one time or another have been under the care of a private physician back to that physician. Patients who have no family physician but "are now or ultimately might be self-sustaining are to be referred to a neighborhood physician." The physician may treat the patient without charge, at a reduced charge agreed upon between them, on a deferred payment basis or may in writing refer the patient back to the dispensary. Emergency cases need not be referred.

The plan was communicated to physicians in June, 1933, but referral blanks for use by the clinics were not ready until January, 1934, and a list of private physicians in Allegheny County was not available until 1935.

Questionnaire Method Used

In April, 1936, questionnaires were sent to twenty-three hospitals in Allegheny County asking whether they were following the plan. Eighteen replied of whom 9 reported that they have been following the plan since its inception without modification. Six have been using the plan for two years modified to suit their individual requirements. One has been using it for one year in a modified way, that is, if the patient states that he has no family physician he is accepted. Two have never used the plan as such but the policy of the dispensary is similar to it.

To discover the actual effect of the plan a special study was made at the out-patient department of the Allegheny General Hospital. From January 1 to August 1, 1935, the department accepted 3,522 new patients and referred 161 new patients to private physicians.

Of the 161 patients referred to private doctors under the plan, 92 returned to the clinic with the required referral slip from the physician. The 69 who did not return presumably were cared for by private physicians. To check this presumption was the purpose of the special study.

Only 52 of the 69 patients could be located, the other 17 having either moved or given inaccurate addresses. Of the 52 patients located, 9 actually went to see a physician as directed. Of these 3 were satisfied with their treatment although in no case did they arrange a payment plan with the doctor, 1 was dissatisfied because no payment plan was arranged, 3 lacked confidence in the doctor and 2 failed to see the doctor on their visit to his office and did not return.

Of the 43 patients who did not see a doctor, 4 failed because they did not understand the instructions, 8 preferred dispensary care, 8 considered their complaints too trivial, 2 wished care immediately, 6 owed the doctor for previous bills, 4 found that their complaint disappeared, 4 lacked confidence in the doctor, the family doctor had died in 2 instances, 2 became bedfast and another too ill to go to the doctor and 2 stated that there was too much red tape.

Fourteen of the patients who did not go to a doctor relied on patent medicines instead, 2 went to cultists, 3 went to other clinics, 1 received emergency treatment, 2 became so ill that they had to call a doctor to their homes and 1 received emergency treatment.

As a result of their experiences, 15 of the patients or their families felt definitely antagonistic toward the Allegheny General Hospital, 25 did not and 12 were indifferent.

From these data it is apparent that the plan has not significantly increased the incomes of the Pittsburgh doctors. Of 3,683 new patients applying to the clinic in seven months, only 7 actually came under the care of private practitioners as a result of the plan.

As far as could be determined from the interviews none of the patients suffered physically from being refused immediate dispensary care. Those with conditions which seemed serious were receiving care of some kind and at least were no worse off at the time visited. From the standpoint of preventive medicine it is impossible to estimate the damage done to patients who either received no care or some palliative type. The hospital undoubtedly saved some money since it routinely makes a medical examination of many of the new dispensary patients.[1]

[1]Caldwell, H. Van Y., Cleveland Plan of Dispensary Admission—Its First Year. Mod. Hosp., March, 1934, p. 92.

[1]Abstract of a master's thesis submitted at the University of Pittsburgh, 1936.

Administrative Case Histories

By DONALD C. SMELZER, M.D.,
and HARRY L. FARRELL, M.D.

IT MUST be realized that the administrator of a hospital is often called upon to make decisions that may not be acceptable in theory to other administrators. In a large hospital these rulings are made to meet emergencies, and in the final analysis the decision must be, directly or indirectly, for the benefit of the patient. Every case must be settled on its merits and not by rule. In many instances where finances enter the picture this important item must be made of secondary consideration. If a hospital accepts a patient, then it must be prepared to meet all legitimate demands of attending physicians for therapeutic aids, including blood, serums, biologicals, oxygen. "Where there is life, there is hope," should always be the attitude of the administration.

1. Expensive Therapeutic Aids

The chief resident physician comes to the administrator and states that there is a case of tetanus in the hospital. The patient is a poor, nondescript individual, penniless and friendless. His condition is considered poor as he is undernourished and generally debilitated. He should have immediate administration of therapeutic doses of antitetanic serum. There is a "long shot" chance that this will cure him of his tetanus. The serum is expensive and if the disease is brought under control and a recovery obtained it will cost the hospital several hundred dollars. It is possible the patient may die after a considerable amount has been expended for the serum already injected, as has been the experience in several cases of tetanus in the past.

There is only one decision for the administrator to make—to begin treatment at once. Arrangements are made for an adequate supply of serum. The patient receives a total of 100,000 units in forty-eight hours and, after a stormy four weeks, recovers.

Similar incidents can be recalled when the demand was for blood transfusions, oxygen, cortin, and other organotherapeutic preparations.

The question now arises as to who is to decide whether certain expensive agents are to be tried. Certainly the administrator should not be called upon to answer this question alone. Experience has shown that the opinion of the individual physician is not always the best to follow. However, when legitimate demands are made for expensive therapeutic preparations after a case has been well worked up, with the necessary consultations, it is folly for an administrator to turn them down.

2. Patients Signing Release

A problem that frequently confronts the administrator is that in which a patient desires to leave the hospital without the consent of the attending physician. A general hospital cannot prevent this type of patient from leaving, but can protect itself by explaining clearly to the patient the seriousness of his illness, the chances he may be taking, the fact that he cannot return to the hospital for future treatment, and by having him sign a recognized form known as "Release Blank." This blank is so worded that when signed, it relieves the hospital and the attending physician of responsibility regardless of the future outcome of the patient's condition.

Of course this problem has a legal aspect and must be considered from many angles. The age of the patient, his mentality, his condition, insofar as deformity is concerned, his vision, hearing and other factors must be taken into consideration. A release signed by a patient under age or otherwise not in a condition to execute a legal document is valueless.

A patient who is allowed to sign his release when suffering from deformity, poor vision or poor hearing, may meet with some accident immediately upon leaving the hospital, and the institution is at once faced with a problem. Even though the hospital has in its possession a signed release blank, it has allowed a patient who is thoroughly incapable of taking care of himself, to leave the hospital. It is always best under such circumstances to have some member of the family come in and sign with the patient, who is then released to the care of this relative. Each of these

angles is important because if the hospital does not have written protection, the criticism it might receive would be unjust and often injurious. The possession of this blank has many times prevented unjust newspaper publicity.

There are two sides to every question, and under certain circumstances the patient is justified in asking to be allowed to sign his own release. On the other hand, in most instances, the patient, in a fit of anger, wants to sign his release and leave. Investigation will reveal that this is because there has been some misunderstanding between the patient and some member of the personnel.

A Time to Be Tactful

When such an occasion arises, a tactful house officer is frequently able to explain the situation to the satisfaction of both parties, and the patient remains in the hospital for further care. When we say "tactful," we mean that the situation is so handled that the patient is not made to feel that we are imploring him or that we are particularly anxious for him to remain, but just trying to show him that this is the best thing for him to do. During this interview it is well to have the patient's clothes at hand, and in the end, to tell him that if he wants to remain and abide by the hospital rules, he may stay. In most instances the interview ends by the patient asking to be allowed to remain.

The other side of the question is that some patients become so obnoxious and undesirable that they are asked to sign a release and leave. Such patients demoralize other patients and frequently cause such disturbance in the ward that it is impossible to give the best care and treatment. If there is a tendency for other patients to become unruly, the ejection of the ringleader will usually quiet the disturbance and restore order.

Another problem frequently encountered with this type of patient, is that he says that he has been told not to sign his name to any papers. This is easily handled by explaining to him that his signature is not essential, and regardless of whether he signs or not he must leave the hospital. In such a case we take the release blank and, in the presence of the patient and some responsible witness, frequently a police officer whom we have made acquainted with the situation, we write across it, "Patient refuses to sign," and make note of the circumstances necessitating the request for him to leave. The witness and house officer then affix their signatures to the blank and this is attached to the patient's hospital record. The admitting officer and admitting department are then notified, and the patient is discharged from the hospital and entered on the "Black List" which brands him as an undesirable and prevents his returning for future care. An example of the value of this procedure is brought out in the following case history:

On Sunday morning, a colored woman, aged thirty, accompanied by her sister, presented herself in the receiving ward with a history of having fallen down a flight of stairs and injured her right arm. Examination revealed that the patient was under the influence of intoxicating drinks and also that there was a complete fracture of both bones of the right forearm with extreme degree of angulation. The resident on duty placed the arm on a straight splint, called for an anesthetist, and ordered the fluoroscopic room for reduction of the fracture and application of the cast.

About ten minutes later the patient came in from the waiting room and stated that her arm felt better now and that she was not going to wait any longer. The resident on duty explained to her that the reason for her improvement was that the bones were immobilized, but that her arm had not been set. He also explained the reason why it was necessary to have the fluoroscope, and the patient asleep, but the patient insisted on going. The sister was then approached and she agreed with her sister that since she felt better, she did not think it necessary to have anything further done. The resident, after realizing the futility of his efforts, had both sign the release and allowed them to go.

Two days later the same patient went to another hospital with the story that we had refused her treatment and that she did not know for what reason. The chief surgeon of this hospital learned of the case and phoned us. When he was given the true story the second hospital refused to treat the patient and sent her back to us, at which time we were unable to reduce the fracture, and the patient had to be admitted and open reduction was done as soon as it was possible. Had not the release blank been signed, we should have been open to criticism from this second hospital and perhaps to legal involvement.

3. Operation Permits

Another perplexing difficulty is how to obtain the patient's permission for an operation. As a rule we have little difficulty in getting the patient's consent to admission, but when he is approached to sign the operative permit, we at times meet with resistance.

A large hospital doing a great deal of charity work must have some routine method by which this situation is handled. The method commonly employed is that in which the patient signs, on

admission, a blank giving his or her consent for any treatment or operative procedure deemed advisable for his or her welfare. A signature to such a blank should not be accepted unless the patient is of age or unless the party signing is the one legally responsible for the patient. If, after admission, the patient refuses to submit to an operation, then the situation is covered by the release blank method.

Emergency Work May Be Held Up

Emergency procedures are often halted or even held up entirely because the patient refuses to give consent for operative procedure or because he is not of age. A phase of this problem frequently encountered, is that in which a child is sent unaccompanied to the emergency department with some complaint which warrants hospitalization and operation; yet the hospital cannot admit the patient and start treatment until the parents appear and signify in writing their desire for the hospital to assume the responsibility for the care of their child.

The following incident serves to show the expense and trouble caused the hospital and attending physicians, and the influence on the outcome insofar as the patient is concerned.

Another colored woman, age thirty, was brought into the emergency department between three and four o'clock on Sunday afternoon. She had a subnormal temperature, a rapid thready pulse, air hunger breathing, with a rigid left-sided abdomen, and extreme degree of shock. The history elicited was that the patient had experienced sharp pain in the abdomen several hours before and that since the onset she had been complaining of a cramplike pain which was gradually getting worse. Pelvic examination was made and a cul de sac was found to be bulging into the vagina. There was every sign of peritoneal irritation. A diagnosis of ruptured ectopic pregnancy was made and the case reported immediately to the chief of service. The patient was then typed, blood donors were obtained, the operating room was prepared for the emergency, and in less than an hour everything was in readiness for an operation and transfusion.

After a short time, the chief arrived and was ready for the patient to be sent to the operating room, when she refused to give consent for an operation. Her condition at this time was worse than on her admission and signs of internal hemorrhage were more pronounced. She was pleaded with to consent to operation as a life saving procedure but she still refused. After a futile attempt to gain the patient's consent, her mother was located and the seriousness of the situation explained to her. She was finally able to convince her daughter that an operation was necessary for her recovery.

We obtained permission for the operation four or five hours after everything was in readiness for the emergency. The operating room had been kept in readiness and the patient was immediately taken up and opened, with confirmation of the preoperative diagnosis. The patient had one transfusion on the table and another a few hours later, but she succumbed sixteen hours after the operation. Had we obtained consent when the patient was first seen, we might have been able to save her life.

All such incidents fortunately do not terminate as did the case cited, but in many instances, the delay alters the outcome considerably and prolongs the patient's hospitalization. The expense to the institution, the time lost and the trouble to the attending physicians, are factors which must also be considered. Many recommendations might be made in regard to this problem, but we shall confine ourselves to saying that to date we have found no method of approach or procedure which completely eliminates this problem.

Since from a legal standpoint the patient does not have to accept the advice of the hospital physician, the administrator and admitting officer will continue to be often confronted by this perplexing problem.

4. Magazine Agents, Peddlers

Every hospital at some time or other is bothered by men claiming to be agents for magazines, candy, novelties, who gain access to the floors and try to interest nurses, personnel and patients in purchasing their wares. It might seem a simple problem to keep these people out, but they do get in and of course should be warned off the premises as soon as discovered. Many of them are thieves, using the magazine or other article only as a "front." Many hospitals have had their nurses' homes robbed, patients' valuables stolen and even expensive apparatus pilfered by these "agents."

They are usually clever and rarely leave clues behind. The unfortunate part is that suspicion often falls on innocent persons employed by the institution. When a patient is the victim, the reputation of the hospital is hurt, because the patient feels that the hospital authorities should guard him against such occurrences.

There is only one rule to set up and that is absolutely to prohibit any agent or peddler, from entering the premises. Doormen, elevator operators, nurses and other employees should be instructed to report all such instances to the admin-

istrator's office, which should then take immediate steps to have the individual ejected, even if the police department has to be called.

All reputable representatives of book publishers or nurses' supplies know that the proper place to introduce themselves is the administrator's office. Even they should not be given permission to solicit business from nurses, interns or employees on duty.

The following example will illustrate one of the points mentioned above:

The nurse in charge of a private floor reported that a patient had been robbed of a considerable sum of money while he was out of his room for treatment. He was accompanied by his private nurse who vouched for the loss.

Although the hospital is not liable for such losses, as patients are advised on admission to deposit money and valuables in the hospital safety deposit boxes, nevertheless the administrator must start an investigation at once and do all that is possible to catch the thief and recover the missing valuables.

In this instance, the only hospital personnel on the floor at the time were two nurses and an intern. Each denied having been in the patient's room during his absence or having seeing anyone enter or leave it. The doorman stated that he had chased off the premises a youth who, on several occasions in the past, had "crashed" the door and tried to peddle magazines to patients. He gave an excellent description of the boy. The police department was notified and a complaint registered by the patient. Several weeks elapsed, and nothing happened. Four other hospitals had had similar experiences, and in one a youth was caught redhanded while going through the bureau drawer of an intern. His description fitted the boy who had been seen on the premises the day the patient lost the money. The police finally got him to confess to all of the losses. He had spent all of the money except a small amount, so that restitution was impossible. He was sentenced to two years in a reformatory.

The patient did not openly accuse any of the hospital personnel, but it was known that he "suspected" one of the nurses. He was bitter against the hospital and there was some difficulty in getting his bill settled. This is only one instance of similar occurrences which happen too frequently.

Cooperation for Collection

A METHOD for the cooperation of hospitals with insurance companies to simplify the hospital bills in accident cases covered by insurance was outlined before the recent convention of the New England Hospital Association.

The hospital, after the start of treatment in any cases when the patient is willing and in proper mental condition, and when the patient's attorney, if any, has assented, will secure an authorization from the patient to notify the insurance company of the hospital treatment of the patient and to forward the hospital record of the nature and extent of the injury suffered.

The hospital will ask the patient to sign an order authorizing direct payment of the hospital bill upon payment of the claim, in every case when the patient is willing and in the proper mental condition and when his attorney, if any, has assented. The hospital will send such order or a copy to the insurance company immediately.

Where the patient is a minor, the authorization and order above referred to shall be signed by his parents or guardian.

On request, the hospital will arrange, if the physical and mental condition of the patient is such that in the opinion of the hospital's superintendent no harm will result and with the approval of the patient and his attorney, for an interview and physical examination of the patient by the insurance company's examining physician, in the presence of the attending physician or his representative.

It is understood that in the settlement of cases where the patient or his attorney will not cooperate with the insurance companies in agreeing for a direct payment of reasonable hospital bills, the insurance company will immediately advise the hospital of any settlement made.

It is understood that in the settlement of cases where the insurance company will make no payment, it will promptly notify the hospital involved of the status of such case.

In cases where, because of lack of merit, the insurance company's payment and settlement will not be sufficient to afford full satisfaction or reasonable medical expenses, the insurance company will advise the hospital of the status of the case and attempt to work out some solution whereby the hospital shall receive a fair proportion of the available money in payment of its bill.

Whose Duty Is It...

By JOSEPH C. DOANE, M.D.

To check scientific work?
To judge staff efficiency?

THE average executive not medically trained is loath to explore medical fields and to ascertain the effectiveness of medical care of the patients. This "touch me not" attitude is more easily understood than justified, and should certainly not be assumed by the superintendent in regard to any hospital activity.

Is it safe and proper for a staff to sit in judgment on its own acts? Usually there is no other method by which the efficiency and effectiveness of staff operation can be learned. Who, for example, shall officially note that a patient suffering with pneumonia has undergone an appendectomy because of a mistaken diagnosis? Who shall concern himself about the renal ailment mistaken for inflammation of the vermiform appendix? Who shall inquire the reason for drug overdosage or for the failure to realize the imminence of a hospital suicide?

Surely incidents of this sort and others which concern the acuity of the diagnostic activities of the staff should not escape official recognition and remedy if possible. Errors in diagnosis occur perhaps with no less frequency in the medical wards than in the surgical or other specialty departments. On the other hand, the patient's life is probably less jeopardized by such errors than is the case in the surgical department.

The welfare of ward patients is perhaps more definitely safeguarded than that of private patients. In the former instance, seasoned major staff men care for the patients. In the latter, particularly in institutions with large courtesy staffs, private patients are admitted and treated by young physicians with little if any supervision. This matter cannot be lightly passed without placing upon it the emphasis it deserves, and without also laying the responsibility for such a condition where it belongs, that is, upon the board of trustees.

In some hospitals a commendable consultation plan has been devised which requires that when young physicians are treating seriously ill patients in the private suite, free consultation with older members is available, if the patient is unable to pay therefor. The patient suffering with some serious ailment deserves the best and most seasoned therapeutic advice. The fact that a young physician may mistake the consultation principle for a confession of inadequacy on his part, should in no way prevent the hospital from protecting its patients.

It has been suggested that there exists a tendency on the part of staff committees and conferences to ascribe as "unpreventable" factors which have produced death or prolonged hospitalization. It is possible that an impersonal and more judicial attitude would have at least pointed out methods of prevention which if adopted would redound to the welfare of the hospital and its patients. Whose duty is it to apply the scientific yardstick and evaluate the effectiveness of the treatment as a whole? The superintendent, even though not medically trained, has certain basic facts which will assist in forming some rough opinion at least as to the type of work being performed.

Is the handling in the institutional emergency ward of accident patients, particularly those who have suffered a head injury efficient? The method of treating such individuals in these days of tragic automobile accidents should be far from a hit-and-miss matter. The emergency ward bulletin board should contain detailed instructions to the accident ward physician as to what is to be done when such a case is admitted. This statement of course presupposes that there is a concensus on the part of staff surgeons as to the best modern methods to employ in such cases, or that a neurosurgical department exists with a unification of control which will make the adoption of such a technique possible.

It goes almost without saying that adjacent to

a hospital emergency ward should be the surgical ward itself, or else sufficient beds in which such patients may be temporarily treated until they have recovered from shock. The hospital must of necessity provide twenty-four-hour x-ray service, a matter too often neglected by institutions. It is an advantage if there can be resident in the hospital someone capable of doing this work. The delay too often observed in night, holiday and week-end x-ray service is inexcusable.

Emergencies Demand Prompt Action

The promptness with which emergency service is rendered to accident cases is another factor easy to observe, although often less simple of correction. The redressing of fractures whether by the institution's out-patient department or through reference to the family physician is another question worthy of study.

General surgeons are notoriously disinterested in head surgery, and it is wise for the administrator to learn whether old-fashioned emergency operative methods or newer more conservative ideas in the treatment of head cases are being employed.

Upon whose orders are concussion and fracture cases moved from the emergency ward to the general surgical wards? It is not unreasonable for a nonmedical superintendent to review from time to time mortality and morbidity statistics of the institution's traumatic work and to compare them with those of other hospitals. From a study of this type there might emanate such a progressive step as the inauguration of a fracture service or the institution of a neurosurgical department.

Classification and investigation of deaths occurring in the hospital is often informative. The minutes of surgical staff conferences will quickly reveal the general attitude of those present. If a tendency to pass over the details concerned in a surgical or medical death exists, or if there is revealed an individual or staff sensitivity to censure, the monthly conference cannot be as useful as it should.

To be sure, it is not pleasant although it should be interesting to classify deaths as due to the patient's disease, to a mistaken diagnosis or to an error in technique or judgment. Nevertheless, it is reasonable for a hospital board to require at the end of the year a report setting forth the mortality and morbidity records of its operating surgeons. A knowledge of the attitude which a staff presents toward its own mistakes and toward a thorough search for causative factors which result in the loss of a patient's life will go far toward revealing the scientific safety of such a group. Individual or collective egotism is dangerous.

Is any emergency patient, regardless of economic classification, permitted to die without a visiting physician having seen, examined and prescribed for him? This should be a rare incident indeed. In addition, an inquiry as to what length of time intervened between the last visit of the hospital intern and the death of the patient might indicate the general alertness of the intern staff.

In the consideration of hospital death statistics, the length of time during which patients were in the hospital and under treatment before expiring, offers an interesting topic for study. It is without doubt all too common for physicians sensing the approach of death to move the patient to the hospital so that they can escape blame. In some cases where home conditions are deplorable this may be justified. In most instances, it is not fair to the patient or to the hospital. The hospital executive might with profit study each month the circumstances connected with the illness and treatment of patients who die in the institution.

The board of trustees and the executive should be interested in efforts made by staff efficiency committees to prevent the practice of precipitate, delayed or night surgery with unusual or unnecessary frequency. The American College of Surgeons has done much to bring about a more thorough and careful preoperative study of patients. To be sure, one observes from time to time physicians who appear to be overcautious in the application of surgical treatment. Such an attitude, however, is preferable to precipitate operating.

What of the Night Work?

It would be interesting if the facts which relate to the necessity for frequent night surgery were to be carefully studied. Of course true emergency operations should not be delayed and yet it is suspected that for one of several reasons the admission of a surgical case to a hospital may be retarded without justification, or when such a case is admitted, that the surgery which follows may be properly classed as precipitate.

Probably the efficiency of surgeons and nurses in early morning hours is at its lowest ebb, and the operation is more likely to be performed by an associate rather than by the chief surgeon.

A committee of the staff or some other informed person may well request from the operating room supervisor rather full details in regard to all night work. Nor would it seem out of reason for a periodic comparison to be made between preoperative diagnostic statements and those submitted upon the basis of pathologic findings. Such statements would go a long way toward substantiating or refuting the need for emergency work.

In the final analysis, a comparison between

ante-mortem diagnoses and those discovered at autopsy indicates the diagnostic skill of staff men. How such statements are to be presented is a matter of procedure rather than of principle, but no staff is worthy of the name that shuns such a presentation for fear of individual or group embarrassment. Information as to the number of consultations called, the promptness with which they were answered, the methods by which they were carried on, indicates the presence or absence of a casual attitude in the medical practice.

Don't Be Ridiculous

Finally, it should be of interest to those in authority to note whether young physicians are referring cases from the dispensary for admission to the surgical or medical departments, which, upon further study, fail to justify such an expense on the part of the hospital or upon the time of its staff men. To refer a man of seventy years to an institution for a tonsillectomy or a turbinectomy is the acme of inexcusable avidity to operate. And yet, just such ridiculous incidents take place.

A greater effort should be made to create in staff conferences an unflinching attitude toward the truth, and to select as members of staff efficiency committees, those who are willing to face the facts and apply the remedies indicated.

When a patient with a contagious disease enters the hospital what efforts are made to learn who is responsible for his admission, and whose duty is it to inaugurate proper and effective quarantines? Too often an inexperienced chief resident physician is assigned to such duty. His vision as to the necessary steps to take is of necessity blunted by his lack of experience, and still, placed in his hands is the matter of safeguarding lives.

Whose duty is it to check details of precautions to be taken in the case of suspicious throats, of typhoid or pneumonia patients? Usually, this falls within the realm of the nurse's work. This is an unjustifiable responsibility to place upon her.

Infections which take place in the surgical ward are inclined to be overlooked or to be set down as unavoidable. The steps necessary to obtain the release by local health officers of patients who have suffered with infectious or contagious diseases are important both from a legal and a community standpoint. Again, such matters are usually assigned to a young physician who eventually learns what is to be done but often at the expense of mistakes made through lack of information.

Methods employed both from a legal and medical standpoint in handling patients suffering from abortion, whether criminal or not, should be made a matter of study by someone. In most locations, it is incumbent upon the hospital to notify the local police department of the admission of a patient critically ill as the result of an abortion. It is not the business of the hospital to classify this condition as to legality or illegality.

If the institution permits the patient to become comatose without having given the police an opportunity to learn from her as to the one responsible for her condition, it becomes a part of the crime and serves to retard if not entirely prevent the processes of justice. Too often, because an abortion patient is referred by a senior staff member, a young chief resident physician is inclined to gloss over the event and fail to report it. The attitude of the hospital should be a purely neutral one in this matter. Reporting the receipt of the patient whose condition seems to indicate malpractice should be mandatory no matter what the patient's economic grade may be.

The scientific check on the work performed in the dispensary might consist of learning such facts as the number of revisits permitted; the attempts to prevent dispensary abuse, not only by chronic patients receiving no benefit from such service, but by those who should pay for such care. The efficiency of the prescription system employed and the effectiveness of efforts to require the payment for drugs from those who are able to pay are also matters which should interest the executive. Dispensary work is frequently so casually done that patients who should be admitted for bed care are sent home and those who do not require such handling are referred for admission.

A Fine Machine but Does It Work?

Sufficient has been said to indicate that the presence of fine buildings, good laboratories and even highly trained personnel is futile if hospital executives having set the organization machine in motion relax, feeling sure that its functioning will always be efficient. The type of medical care rendered in the hospital is the business of the board and of the hospital executive. It should not be left entirely in the hands of a staff committee which is not required to report the details of its deliberations. Chief resident physicians and others who are inexperienced should not be required to assume responsibility. To obtain an effective check on the scientific service rendered is difficult because of the following drawbacks:

1. The great variation in individual training and experience of staff men.
2. The abstract nature of medical judgment and its effect on the patient.
3. The existence of an improper attitude on the part of the hospital as to the absence of its responsibility or the presence of an improper institutional and staff organization.

Someone Has Asked—

Should Visiting Physicians Practice Only Their Specialties?

This is an interesting query and one which has been discussed before in these columns. Practically, it implies the existence of a rule which forbids the visiting internist from performing surgery within the hospital, and the surgeon, laryngologist or pediatrist from treating patients not covered by the field in which they claim to be especially proficient.

There is much to support a regulation which insists upon an adherence to their specialty by members of the major staff. If a physician is not able to support himself and family by the practice of his specialty when he attains a major staff position, it is questionable whether he is sufficiently proficient in this line of work to be denominated as the hospital's specialist therein. To practice all types of specialty medicine in the hospital is not likely to create respect for an incumbent of a major staff position.

The fly in the ointment is not the limitation of the practice of a physician in the hospital wards but the restriction placed upon him insofar as private room service is concerned. An extension of privileges within his own specialty is less likely to work harm to the physician than the granting of permission to practice in other specialties. A surgeon may be permitted to perform rectal, nose and throat or genito-urinary surgery, whereas to permit him to treat pneumonia would be less reasonable. The hospital should aim at the creation of a staff composed of specialists who are such in reality as well as in name.

Is M.D. Degree Essential for Treating Hospital Patients?

This matter concerns every hospital. Scarcely a day passes but a contest arises in some community as to what limitation of privileges should be fixed relative to the treatment of patients in a general hospital. The osteopath, the chiropractor and other cultists demand that hospital doors be opened to them. The American Medical Association, however, demands that only registered physicians and qualified registered nurses supervise the work done within the institutions of which it approves.

Even all those who possess a medical degree should not be permitted to practice in the hospital since even in this group one sometimes finds those of questionable ability and uncertain ethics. The staff dentist should be permitted to admit patients to hospital rooms for the performance of work for which he is qualified. Indeed, more and more are staff physicians being restricted to the practice of their own specialty within hospitals of standing. Certainly, no cultist should be admitted and the closest scrutiny should be given physicians seeking staff and courtesy privileges.

Only in this way may the interests of patients be properly safeguarded and, no matter what the cost, hospital boards must flatly refuse to admit anyone who has not expended the time and money necessary to prepare himself for the practice of the art and science of medicine.

Should 8-Hour Shift Be Allowed Private Nurse?

In an Eastern institution a doctor recently requested the assignment of three nurses to a private patient, each working for a period of eight hours and each receiving four dollars a day.

It will be quickly seen insofar as the fee for nursing service is concerned that these three nurses cost the patient no more than two nurses at the rate usual at this institution, namely, six dollars per day. On the other hand, the total expense to the patient exceeded that necessary for the service of two nurses because the board for each nurse was set at five dollars a week for one meal a day.

Since this particular patient was very ill, this arrangement of nursing service seemed most advantageous. The principle involved, however, concerned itself not with this individual patient or even with the three nurses engaged, but with the matter of establishing a precedent which would affect others.

It would seem that this is one method of lessening the number of unemployed nurses and of caring for very ill patients who require intensive nursing. The method of fixing nursing rates and hours, however, should be well worked out. In the first place, this matter should be discussed with the hospital nursing alumnae association, its recommendations being referred to the nurses' training school committee of the hospital board to be later approved or rejected by the board itself or by its executive committee. In no other way can all the parties at interest, the nurse, the doctor and the hospital board, be given an opportunity fully to consider this vital matter. The above arrangement or some adaptation of it is to be recommended, but before it is adopted it should be thoroughly discussed by all concerned.

Shall the Maternity Department Offer a Flat Rate?

A distressed superintendent who has recently observed a gradual decline in the census of his maternity department asks this question. The problem which confronts this executive is not unique in his locality, for it is observed in hospitals throughout the country. It is no doubt due to a falling birth rate, a keener urge on the part of the doctor to deliver his patients at home and an inability on the part of the patient to meet hospital rates.

Not a few hospitals have carried out as an expedient a readjustment of room charges. There are many who offer a flat rate for a ten-day stay, this figure varying from forty-five to fifty-five dollars for accommodations in a two or three-bed ward. These rates include delivery room fee as well as necessary drugs. No extra charge is made for an anesthetic, although the physician's fee is not included.

This particular plan has proved satisfactory to the patient because she is able to estimate rather definitely the cost of her hospital stay. She also knows what additional days at pro-rated charges will cost her. The flat rate in the maternity ward has increased the occupancy in hospitals that have adopted this plan and it is recommended as a useful expedient to increase the income of the maternity ward and the hospital's usefulness.

If you have any questions to ask, the Editors will be glad to discuss them in a forthcoming issue

PLANT OPERATION • • • •

Conducted by John R. Mannix and R. C. Buerki, M.D.

What to Do About Floors

By Jens Flikeid

Daily maintenance carried out with the proper tools is of major importance in the care of all types of hospital floors

IN THE past few years, floor maintenance engineers have seen many improvements made in types of floors, floor materials and methods of floor maintenance. The old-fashioned scrubbing of wood floors, the later treatment with mineral oils and the more recent use of wood floor preservatives (a combination of mineral and vegetable oils) have given way to more modern methods of treatment.

Increased knowledge about floors other than wood has led to the more extensive use of substitutes for wood and has caused the adoption of floor treatments and maintenance methods unknown a few short years ago.

All marble, terrazzo and travertine floors should be cleaned with a high grade, neutral, vegetable oil base soap containing no free coloring matter that might stain the light colored stone or chips.

Trisodium phosphate, sodium metasilicate, soda ash, or any other cleaners of the salt crystal type should be used infrequently on these floors. The diluted salts seep into the cracks and pores of the marble and cement, and if used continuously, accumulate within the cracks in crystalline form until the pressure exerted breaks out particles of the marble or cement. Thus a rough and unsightly looking floor, difficult to keep clean, is created.

If unavoidable conditions make it necessary to use any of the salt crystal cleaners, the floor should first be covered with clear water to fill the cracks and pores and to prevent admission of any of the cleaning mixture.

A nonscratching, abrasive scouring powder may be used occasionally to remove any lime or hardness deposited by hard water and left there, causing the floor surface to appear discolored. However, a high grade, neutral, vegetable oil base soap should be the principal cleaning agent for use on these floors. The floor surface should always be rinsed thoroughly, regardless of the kind of cleaning agent used.

A colorless cement floor filler may be applied in a very thin coat to the surfaces of the terrazzo and travertine floors. This will fill the pores and prevent the penetration of stains that might easily spoil the appearance of the floors. The same results can be obtained by the use of two or three thin coats of water emulsion wax. The main objection to the latter treatment on hard surfaced floors is that it may leave the floor slippery and create a safety hazard. Water emulsion wax is generally recommended for use on marble floors.

Slipperiness may be reduced on these hard surfaced floors by mixing the water emulsion wax with an equal amount of water for the first two coats and then applying a third coat full strength, but as thin as possible.

Care of Rubber Floors

Rubber tile and rubber carpets are resilient and noiseless to walk on and are therefore used most often in spaces where quiet is required. They are also used on inclines or ramps where the resiliency creates a gripping quality that prevents slipping.

Rubber tile and carpets should not be used in kitchens or other rooms in which grease, mineral oils, hot water, alkalies or spirits are often spilled on the floor. These are harmful to rubber and shorten its life. The exposure of rubber to sunshine and extreme weather changes is equally harmful and should be avoided as much as possible.

Strong alkalies or soaps and abrasives should not be used in cleaning rubber floors; only a mild mixture of cleaning powder or a high grade neutral soap should be used, and even then no oftener than necessary to keep the floor clean. The daily maintenance should be relied on for the upkeep of the floor. If a glossier surface is desired, a thin coat of water emulsion wax may be used on the rubber tile floor, provided it does not create a hazard.

Since rubber carpets are used mainly to prevent slipping, it is inadvisable to use wax on them.

Care of Linoleum and Cork Floors

Linoleum, cork tile and cork carpet floors are manufactured of ground, compressed cork, or strips of cork combined with oxidized linseed oil rolled out into sheets of varying thicknesses and widths and then baked.

Since linseed oil can generally be dissolved by solvent spirits or be made brittle by highly alkaline or caustic materials, only a mild, neutral soap should be used on floors made of this material.

These floors should not be flooded with water or scrubbed too frequently, as the soap and water seeps into the cracks, joints and edges, and, finding its way under the linoleum, cork carpet or cork tile, slowly softens and disintegrates the material. In addition to shortening the life of the material, a disagreeable odor is created.

This type of flooring can be kept in good condition and made to last a long time by the use of a water emulsion wax treatment. The bright drying water wax is preferable as it reduces the labor and cost of the original application as well as all subsequent applications.

To prepare the floor for the wax treatment, it should first be cleaned thoroughly to remove greases and other substances to which the wax will not adhere, and then rinsed to remove the loosened dirt and the soap.

The nonpolishing or bright drying wax should then be applied to the floor surface with a lintless cloth or mop placed in a mop holder or lamb's wool applicator. The application should consist of three coats, all without rubbing, and with about a thirty-minute interval between each coat. This will bring out the beauty of the colors and protect the surface of the floor against wear.

The weekly or monthly attention to these floors should consist of a light mopping with a mop wrung out in cold water to which a small amount of water emulsion wax has been added, followed by a rubbing with a dry mop. This will remove the surface dirt that cannot be removed with a sweeping mop, and renew the gloss.

The sections of floor receiving the heaviest wear should be retreated periodically or as often as necessary to keep the linoleum or cork from becoming exposed. This will prevent wear of the floor. The retreatment of the entire floor each time, without first removing all the old wax, will build up a gummy substance on the unworn parts, which will catch and hold the dirt. Also, retreating the entire floor each time a spot becomes worn is uneconomical.

If the floors are old or if the surface glaze has been worn off, it might be necessary to apply a thin coat of linoleum lacquer or varnish to the surface

the maintenance cost will be much ever, if they are oil-stained, it may be rooms where liquid is spilled and a

before applying the water wax. Before any attempt is made to apply either lacquer or varnish, however, all wax, dirt or grease must be thoroughly removed from the floor surface or the lacquer or varnish will not adhere to the floor.

Care of Asphalt Floors

Any floor materials made wholly or partly of asphalt should preferably not be laid in kitchens, garages or other rooms located directly above a boiler room; neither should they be used elsewhere where high temperatures are maintained.

These floors are economical to install and withstand moisture better than most floors. However, they are quickly disintegrated by grease, mineral oils and oil solvents, and become brittle from exposure to extreme heat and any alkalies. Neutral soap should be used for cleaning, and water emulsion wax for treating, following the same methods used on linoleum, cork tile and cork carpets.

Floor seals or fillers should not be used on asphalt tile floors, as they are usually installed in patterns calling for combinations of more colors than one, and since oils cause them to dissolve, the colors run from one tile to the next, resulting in a botchy looking job, difficult to repair.

Troweled asphalt, on the other hand, is generally made of one color throughout, so if the surface becomes rough or slightly porous or if a protection is needed to prevent it from staining, a seal, applied with care, will form a better base for later water emulsion wax treatments.

In addition to the floors already mentioned herein, there are many other types in use, most of them combinations of asphalt, asbestos, magnesite, wood flour and old rubber.

Try Experiments

The kind of treatment they should receive depends upon which of the materials referred to predominates. If this is known, then the treatment to be used on the floor must be one that the predominating constituent will stand. However, when the main component part of the floor is unknown, and the manufacturer or his agent has not specified the type of material to use in its maintenance, then the individual responsible for its upkeep should experiment on a sample of the material or on an out-of-the-way section of the floor before attempting to treat the entire floor.

It has many times proved advantageous to make such private experiments even though an expert or a salesman has recommended a certain material for use on the floor. Some of the special floors look so much alike that it is easy to make a mistake in identifying the base or predominant ingredient they contain.

Care of Wood Floors

So much has been written in the past on previous wood floor experiences and practices that, except to make comparisons or to stress a point in favor of the most modern methods in the field of wood floor maintenance, no mention will be made of them.

Penetrating floor seals with the appearance of varnish but with the faculty of much deeper penetration into the wood are now used extensively for treating maple and soft wood floors. These materials are applied in the following manner:

First, the old treatment or the roughness that results from scrubbing or wear must be removed to prepare the wood for the treatment. Sanding the surface has proved to be the best method for this purpose, as it leaves the floor even in color, level and free from any alkali or oil soaked particles. The penetrating floor seal is an almost permanent finish, and it does not pay to apply it to a half-cleaned or partly prepared floor.

Then the floor must be swept thoroughly with a bristle brush lengthwise of the boards, to remove all dirt and dust from the cracks. The next step is to pick up the fine dust with a lightly treated sweeping mop.

Applying Floor Seal

The first step in the application procedure is to dip a cloth in the penetrating floor seal and apply it to the floor around the edges and near stationary furniture. This is done to prevent splashing the mopboard or furniture, which happens when a mop is used. The edge treatment should extend from the outer edge to about 1 foot from mopboard or equipment.

The penetrating floor seal should then be poured on the floor from its container. Walking crosswise of the boards, begin about 6 feet from one end of the room and pour the material in spaces about 6 feet apart, until the opposite wall is reached. This material should then be spread with a mop and the intervening spaces covered, using a lengthwise and crosswise stroke so the material will be spread evenly over the entire surface of the floor. If the texture of the wood is normal and dry, 1 gallon of the penetrating floor seal to each hundred square feet will be sufficient. However, as much material as is needed generously to cover the floor should be used.

Any surplus material remaining on the surface of the floor at the end of thirty minutes should be removed with a squeegee or a dry mop. The complete removal of the surplus material will make the last operation less difficult. If the material is allowed to remain any longer than thirty minutes, it will become gummy.

An interval of at least seventy-two hours should be allowed before the final step is undertaken. This step consists of buffing with a steel wool machine until the surface material and the raised portions of the wood have been removed, leaving the floor hard and polished.

Applying a thin coat of spirit wax, buffed to a polish, protects this finished surface for a long time. This is not a necessary part of the sealing operation and may be omitted if there is any fear of slippery floors.

Mops or cloths that have been immersed or impregnated with a penetrating floor seal should be burned or placed where they will do no damage each night, or when the job is completed, as they are subject to spontaneous combustion. They should be immersed in water or in the floor material if they are to be used again after work has been suspended for a period of time.

Periodic Maintenance

The periodic maintenance of this type of finished floor consists of a cleaning operation (using a good oil cleaner) and a light touching up of the worn parts.

The cleaning operation should proceed as follows:

First, sweep the floor thoroughly, following the instructions given for preparing the floor for the first treatment.

Then, immerse the mop in a pail of oil cleaner and wring it out well. Proceed to rub the floor lengthwise of the boards, exerting pressure on the mop. When it is needed to remove a stubborn stain, use a pad of steel wool under the mop.

Rinse the mop in the oil cleaner, wring it out well and go over the floor again, picking up the loosened dirt.

After the floor has become dry, it should be rubbed briskly with a dry mop or cloth fastened into a small mop holder. This should remove the dullness and bring out the original polish. If it does not, or if the polishing with the dry mop alone is too difficult, a pad of steel wool under the mop will speed up this work.

Touching up the worn parts of the floor should be done with a cloth and the same kind of penetrating floor seal used in the original treatment, thinned with a solvent such as turpentine. This material should be applied in one very thin coat, beginning in the middle of the worn space and working out toward the edges. This prevents the material from being applied too heavily along the edges of the worn spots where the wear is generally much less than in the middle. If the patched sections are too noticeable when the material becomes dry, a light steel-woolling will blend it in with the rest of the floor.

It will be found that the original cost of the penetrating floor seal treatment, applied in the manner advocated herein, will be quite high, but

the maintenance cost will be much below that of any other method, and over a period of years it will prove itself to be the most economical treatment that can be used on wood floors.

Do Not Scrub Wood Floors

Contrary to general opinion, the scrubbing of wood floors is one of the most expensive methods of floor maintenance known. If clean and sanitary buildings are desired, this operation must be repeated at least once a month. The labor time involved is enormous, the soap or scrubbing mixture, when the work is done so often, becomes costly, and the water and alkalies used in the scrubbing operation damage the wood so the floors must be replaced quite often. Floors that have been scrubbed with soap and water never look well, for they are generally grayish in color and become soiled when the first person walks upon them after they have been scrubbed.

Mineral oil and floor preservative treatments are not as costly in the first treatment as the penetrating floor seal, but if they are to be effective, the entire floor must be cleaned and retreated at least three times a year. These treatments are not as harmful to the wood as the materials used in scrubbing, and they look much better on the floor than scrubbing materials, but they become dark and unsightly on unworn parts of the floor.

On the other hand, the original cost of the penetrating floor seal treatment may be high, but the maintenance cost is exceedingly low, as it needs no retreatment except for a cleaning and a light patching of the worn parts about once a year. The penetrating floor seal protects the wood against wear and preserves it better than any other known material, as it fills the pores with its gummy constituents, creating additional wearing surface and protecting the cellulose matter against decay. It presents a beautiful appearance, when well cared for, and the daily maintenance is less difficult because of its smooth, hard surface.

Care of Cement Floors

Difficulties are encountered with cement floors when (1) an inferior grade of sand or cement is used, (2) the amounts of each are not in the right proportions, (3) the right amount of moisture is not added, or (4) the mixture is allowed to freeze.

Few cement floors are perfect, but even the best of them can be improved in appearance and wearing quality by the use of a good cement floor filler. The poorest cement floor can often be saved from further disintegration, and its life prolonged greatly, by the use of this material.

All cement floors must be cleaned thoroughly before being treated. This can usually be done by scrubbing with a good oil base soap mixture. However, if they are oil-stained, it may be necessary to use a cleaning powder such as trisodium phosphate, sodium metasilicate, soda ash or some of the commercially marketed products. The user must bear in mind, however, that cleaning powders of the salt crystal type should not be used unless the floor has first been covered with clear water and the floor rinsed until any indication of alkaline cleaners is entirely removed. Floor materials will generally not adhere well to the cement and often they do not dry properly if any free alkali or caustic is present on the floor.

Cement floor filler should be applied in the following manner:

First, sweep the floor clean to remove all foreign materials.

Applying the Filler

Then, apply the cement floor filler to the edge of the floor with a cloth that has been well wrung out in the material, extending in about 1 foot from the outside edges of the room or from any stationary equipment.

Apply the cement floor filler to the remainder of the floor in one thin coat with a mop that has been well wrung out in the material, working both lengthwise and crosswise of each section, so all parts of the floor will be treated evenly. Any worn parts of the floor, which appear as dull spots on an otherwise shiny floor, may be given another thin coat the following day.

Cement floors that are laid directly upon the ground should be dried out longer before the application of filler; they must be treated more sparingly with the material, and they dry much more slowly. If the cement appears to be damp to the touch, it should not be treated with cement floor filler.

Subsequent treatments should be made in much the same manner, except that it is best not to apply the cement floor filler to the edges or other parts of the floor that receive little or no wear unless all of the old material has been removed from the floor. This can usually be accomplished by the use of lye, or a similar material, diluted with water.

It is recommended that parallel lines be drawn from 8 to 12 inches from the walls, wall furniture, lockers and pillars, outside of which no cement floor filler should be applied after the first treatment, except at doorways where either curves or angles may be made to separate the worn and unworn parts of the floor. The worn parts of the floor should be within the symmetrical boundary lines. Continuous retreatment of unworn parts of a floor builds up a thick, gummy surface which catches and holds dirt. The result is a spotted, ugly looking floor, instead of a clean, even-colored one.

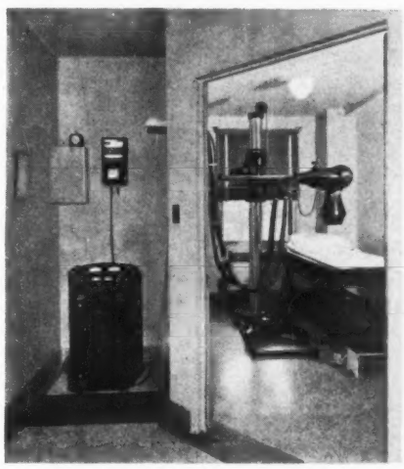
The daily maintenance of floors should consist mainly of a thorough sweeping, except in kitchens and rooms where liquid is spilled and a daily wet mopping is necessary.

The use of proper tools for sweeping is most important in the endurance and appearance of the floors and the finishes on them. It has been proved beyond any doubt that the sweeping mop, if treated properly and used correctly and constantly, will keep floors and finishes in the best possible condition for a longer period of time than any other method. When the dirt is too heavy to be removed with a sweeping mop, it may be swept with a bristle brush, but this operation should be followed by a mop sweeping.

This important point should be brought out here: The amount of mop treatment to be used on the sweeping mop is determined by the treatment the floor has received. Floors treated with seals, oils, spirit waxes and the like will not be harmed by a fairly heavy mop treatment on the mop.

New Apparatus Facilitates Deep Ray Therapy

St. Mary of Nazareth Hospital of Chicago has recently added to its radiologic facilities the deep x-ray therapy apparatus illustrated here. Because of the continuous progress in the study and treatment of various



malignancies, this new installation has been welcomed as an aid in securing better results.

The therapy stand is mounted on floor rails, which makes it possible to adjust the tube stand to any desired position. All the latest safety features are incorporated in this equipment. A meter which indicates whether the x-rays are on or off, whether the radiation shutter is open or closed and what filters are inserted in the filter slot, is placed directly above the control unit in a position where it is at all times easily visible. This eliminates the need of entering the treatment room to check and determine if the proper filters have been inserted in place.

Disinfecting Clinical Thermometers

By E. E. Ecker, Ph.D., and Ruth Smith, M.A.

The third of a series of studies on methods of sterilization adapted to hospital practice

COMPARATIVELY little accurate work has been done on the disinfection of clinical thermometers. Ryan and Miller[1] have reviewed the most recent literature on the subject and studied four methods of disinfection of mouth thermometers.

Bichloride of mercury 1:2000 for one-half minute was found to be the most efficient bacteriologically, cheapest and shortest method of disinfection. Bichloride of mercury 1:1000 for one minute was found to give 100 per cent disinfection of rectal thermometers. In their work they used large size petri dishes, 150 mm. in diameter. With a sterile bent glass spreader the thermometers were rotated from one side of the plate to the other and back again. This procedure was followed four times.

The authors felt, but have not proved, that by this means all adhering organisms would be removed. Even after disinfection of their instruments the fact of not finding organisms on the plates is no proof that they may not have still been adherent to the markings on the glass. Organisms are bound to stick to markings of such instruments and therefore we decided to incubate the thermometers themselves in large size brain broth tubes for periods of about two weeks.

The procedure generally employed in taking temperatures with mouth thermometers is to rinse, dry and shake the mercury down to 35° C. (95° F.). After using, the instrument is thoroughly washed with soap and water, rinsed and replaced in a disinfectant.

A common procedure with rectal thermometers is to remove the thermometer from 2 per cent cresol, dry with toilet paper, shake and lubricate with vaseline. After use, the mercury is shaken down to 35° C. (95° F.) and the instrument replaced in the disinfectant.

We have smeared mouth thermometers with fresh sputum from cases of lobar pneumonia (Type I). Some thermometers were washed with soap and water and dried with sterile cotton before being placed in the various disinfectants employed. As controls, other contaminated instruments were placed directly into the disinfectants and also in brain broth. In all cases, to avoid inhibition of growth, the disinfectants were first removed by rinsing the thermometer in sterile water and drying with sterile cotton before cultures were made. The thermometer was then placed in brain broth.

The antiseptics used were 95 per cent alcohol, 70 per cent alcohol, merphenyl nitrate 1:1500, merphenyl borate 1:1500 (tincture), 2 per cent cresol, liquid soap and bichloride of mercury 1:1000.

Rectal thermometers were contaminated with fecal material (from a case of suspected typhoid) and treated according to general nursing routine. In addition, the factor of vaseline has been more carefully investigated since it is a fat and the aqueous solution of various antiseptics will of course fail to penetrate fat layers.

Table I gives the results obtained with mouth thermometers. The A column indicates unwashed thermometers while the B column denotes the instruments that have been washed.

From these results it is concluded that soap for a period of five minutes is effective in the mechanical and chemical elimination of organisms, while the alcohol (95 per cent and 70 per cent) completely fails to disinfect. Cresol 2 per cent appears to be better than the liquid soap, but the mercurials are all effective in a period of one minute.

Table II summarizes the results secured with rectal thermometers. The A thermometers in the table were lubricated with vaseline, contaminated with fecal material, immersed in the antiseptic, rinsed, dried and cultured.

The B thermometers in the table were lubricated, contaminated, washed with soap and water, dried with sterile cotton and immersed in the antiseptics, rinsed, dried and cultured.

From these results it is seen that exposures up to thirty minutes, together with a thorough cleansing to remove fats is essential to sterilize the instruments when cresol, liquid soap and H_2Cl_2 aq. 1:1000 are used. Bichloride of mercury aqueous 1:1000 is efficient only when the fatty substances have been thoroughly removed. It is therefore advisable to use a potent mercurial tincture, since such a tincture contains alcohol and acetone which aid in the removal of fatty layers.

Thus the sterilization of mouth thermometers is simpler than that of rectal thermometers because of the use of vaseline on the latter. Since it is

TABLE I—RESULTS OBTAINED WITH MOUTH THERMOMETERS

	1 min.		5 min.		15 min.		30 min.	
	A	B	A	B	A	B	A	B
95% alcohol	+	+	+	+	+	+	+	+
70% alcohol	+	+	+	+	+	+	+	+
Phenylmerc. nitrate aqueous	−	−	−	−	−	−	−	−
Phenylmerc. borate 1:1500 tincture (alcohol 50%—acetone 10%)	−	−	−	−	−	−	−	−
2% cresol	+	−	−	−	−	−	−	−
Liquid soap	+	+	−	−	−	−	−	−
$HgCl_2$ 1:1000	−	−	−	−	−	−	−	−

TABLE II—RESULTS OBTAINED WITH RECTAL THERMOMETERS

	1 min.		5 min.		15 min.		30 min.	
	A	B	A	B	A	B	A	B
2% cresol	+	+	+	+	+	+	+	−
Liquid soap	+	+	+	+	+	+	+	−
$HgCl_2$ 1:1000	+	+	+	+	+	−	+	−
Phenylmerc. borate tincture 1:1500	−	−	−	−	−	−	−	−

TABLE III

Disinfectant	1 min.		5 min.		15 min.		30 min.	
	A	B	A	B	A	B	A	B
Glycerine								
$HgCl_2$ 1:1000 Aqueous	+	−	+	−	+	−	+	−
$HgCl_2$ Tincture 1:1000	−	−	−	−	−	−	−	−
Vaseline								
$HgCl_2$ 1:1000 in 50% alcohol and 10% acetone	+	−	+	−	+	−	−	−
Lubricating Jelly								
$HgCl_2$ 1:1000 Aqueous	+	+	+	+	+	−	+	−
$HgCl_2$ Tincture 1:1000	−	−	−	−	−	−	−	−

A denotes the unwashed thermometers.
B denotes the washed thermometers.

[1]Ryan, V. and Miller, V. B.: Amer. J. of Nur. 23: 197, 1932.

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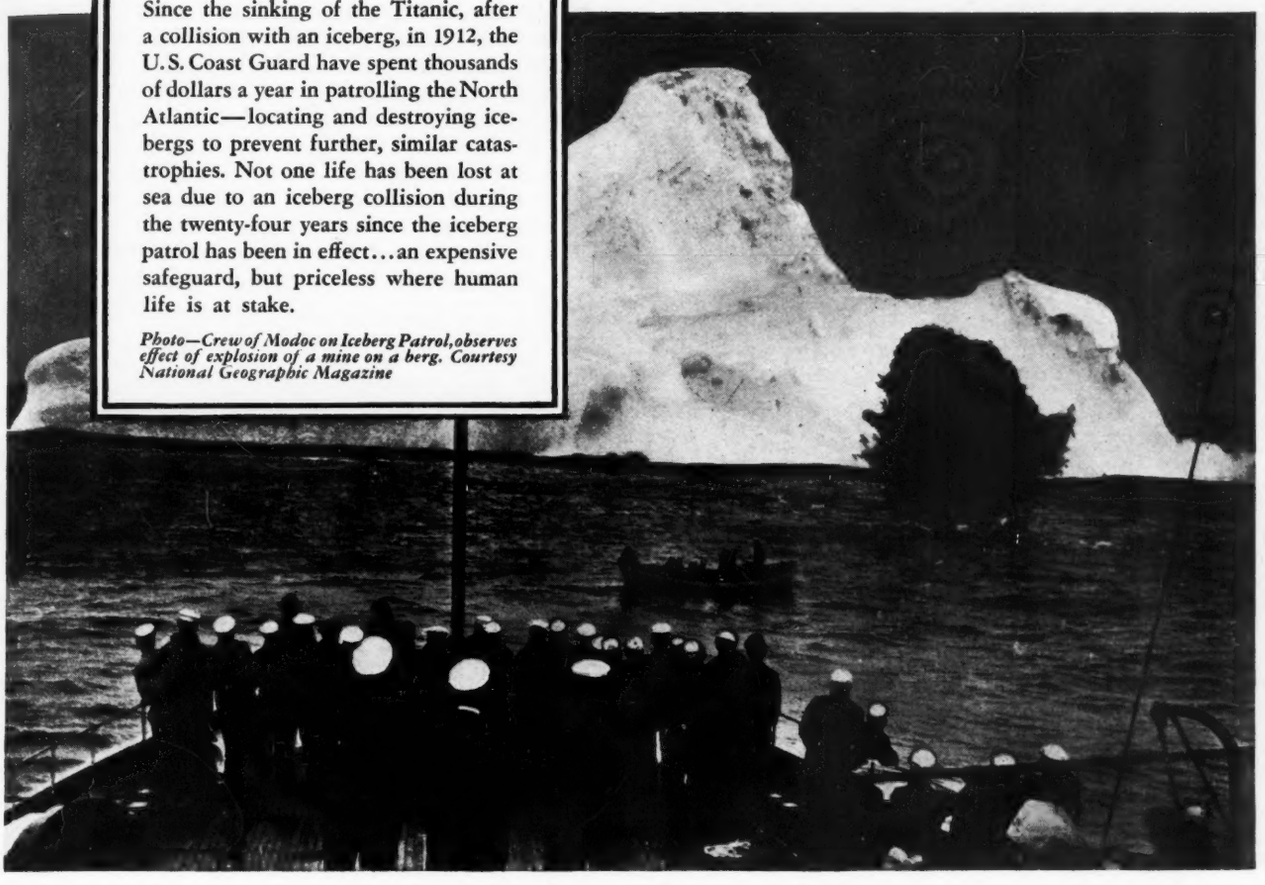
Photo—Crew of Modoc on Iceberg Patrol, observes effect of explosion of a mine on a berg. Courtesy National Geographic Magazine



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probable that if glycerol or KY jelly was used as a lubricant, sterilization would be effected by the same method as is used for mouth thermometers, we compared glycerine, vaseline and lubricating jelly. See Table III.

From these results we may conclude that the unwashed rectal thermometers lubricated with glycerine are not sterilized by aqueous 1:1000 $HgCl_2$ in a period of thirty minutes but when they have been thoroughly cleaned with soap and water and treated with bichloride of mercury they are sterilized in a period of one minute. A bichloride of mercury tincture will readily sterilize both the unwashed and washed thermometers lubricated with glycerine. When treated with a tincture of bichloride of mercury, vaseline lubricated and unwashed rectal thermometers should be exposed to the tincture for a period of more than fifteen minutes to ensure sterility.

Unwashed rectal thermometers lubricated with jelly are not sterilized in a period of thirty minutes in $HgCl_2$ 1:1000 aqueous solution but when thoroughly cleaned they should be exposed to the aqueous solution for more than fifteen minutes to ensure sterility. However, a tincture of $HgCl_2$ will readily sterilize these thermometers.

Summary

By culturing mouth thermometers after treatment with various disinfectants it was found that merphenyl salts both the nitrate and the borate 1:1500 and bichloride of mercury 1:1000, sterilized the thermometers in a period of one minute. Two per cent cresol or liquid soap required five minutes for maximal efficiency. Alcohols (70 and 95 per cent) proved to be ineffective.

In the case of rectal thermometers a merphenyl borate tincture was found to be effective in the short period of one minute and bichloride of mercury 1:1000 only when the fatty substances (lubricating oils) have been thoroughly removed.

Unwashed rectal thermometers lubricated with glycerine are not disinfected by aqueous 1:1000 bichloride of mercury in a period of thirty minutes but when the instruments have been thoroughly cleansed with soap, water and then treated with bichloride of mercury, disinfection was completed in one minute.

A bichloride of mercury tincture containing 50 per cent alcohol and 10 per cent acetone will readily disinfect both the washed and unwashed rectal thermometers lubricated with glycerol. Vaseline lubricated rectal thermometers or unwashed rectal thermometers should be exposed to the bichloride of mercury tincture for a period of more than fifteen minutes to ensure thorough disinfection.

Unwashed rectal thermometers lubricated with a jelly require thirty minutes' exposure to a 1:1000 solution of bichloride of mercury but when thoroughly washed 15 minutes suffices. However, a tincture of bichloride of mercury will readily disinfect these thermometers.

Although cross infections have been attributed to mouth thermometers, this is not likely by means of rectal thermometers. Nevertheless, safety in the use of both can be assured by the methods recommended.

Making Housekeeping Wheels Go Round

By Mary Blount Anderson

IN HANDLING the housekeeping department in a hospital, each day is fraught with problems both interesting and challenging and these are two of the elements that make the task a fascinating one.

From time to time opportunities can be seized upon to simplify the work of the employees and to make more smooth running or efficient the daily routine of the hospital work. It is about a few such things that have been done at Provident Hospital, Chicago, a 150-bed institution, that I shall tell in the following paragraphs.

First, there is the discarded wheel chair that became a linen push cart. The cart was built on the base of the chair and it has greatly facilitated the transporting of the linen between the laundry and the nurses' dormitories.

In making the cart three requirements were considered — (1) strength of body, (2) capacity, (3) ease in handling. An added thought was given to appearance. First the axle and wheels were tested as to their strength to carry a load of 200 to 250 pounds. The measurements of the box are 48 by 20 inches at the bottom, 48 by 23 at the top, and the depth is 24 inches. The material used was white pine—4 pieces, 1x12, 4 feet; 2 pieces, 1x12, 3 feet; 2 pieces, 1x12, 5 feet, the cost of which was $2.80. For corners 4-inch rivets were used—8 at $0.07¾ each, 62 cents. Four "L" rivets for top corners at $0.05 each cost 20 cents.

The two legs at each end of the box are made of 1-inch piping, 18 inches in length, half the length fastened to the box, leaving 9 inches for the box to rest on. These are fastened securely to the box by bolts and nuts. The push bar is made of 1-inch piping, bent in the shape of the original push bar of the chair. For the shaping of the bar and the flanges of the legs, we are indebted to the engineering department. The entire outside of the cart was given two coats of black paint, the inside two coats of white. A 1-inch white trim line, 6 inches from the top edge of the box completed the painting.

Linen push cart loaded with laundry envelopes, all ready for a trip.

The main advantage of the cart is the ease with which it can be handled in comparison to handling an ordinary linen truck such as was previously used. A decided saving in time and energy is made on the five weekly linen delivery trips and the linen delivery man feels highly favored in having this snappy, useful cart at his disposal.

A little brass plate bearing the inscription date of gift of the wheel chair—1918 in memory of a friend who was born in 1846—is the connecting link between a wheel chair that was and the linen cart that is—each doing its bit in the service of the hospital.

Laundry envelopes are another thing we have devised at Provident. They are used in checking and delivering the nurses' linen to their dormitories. They ensure the delivery of the linen in a very neat condition and facilitate the checking and bundling of it. They are quite inexpensive, being made of blue blocked gingham which cost only ten cents a yard on special sale. They are made like a glove case with an opening in the cen-

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The "Standard" QUIET ONE-PIECE CLOSET

● This new type water closet, with bowl and tank in one piece, contributes added appeal and value to patients' bathrooms.

An ever increasingly popular fixture, it has already been installed in many home bathrooms. Patients are sure to appreciate the home-like appearance which it gives to the hospital bathroom and will recognize favorably your efforts to add to their comfort and convenience.

Your maintenance staff, too, is sure to appreciate the economy and long life of the simple-operating, dependable flush and refill fittings of this closet.

And everyone . . . patients in neighboring rooms, doctors, nurses . . . will feel grateful for the *quiet* operation of this fixture. No resounding rush of water, no whistle or pound, but instead a sure, even flush, as silent as possible.

This fixture has just recently been installed in two large hospital additions in California, several hospitals in New York State, and a large nurses' home in Pennsylvania. It lends itself particularly well to modernization as it requires no more floor space or elevation than presently installed fixtures.

In harmony with the movement to use restful color in hospital equipment the "Standard" One-Piece Closet as well as other "Standard" Plumbing Fixtures can be had in choice of ten colors as well as black or white.

"Standard" PLUMBING FIXTURES *for* HOSPITALS

Standard Sanitary Mfg. Co.

HOSPITAL FIXTURES DIVISION

PITTSBURGH, PA.

Division of AMERICAN RADIATOR & STANDARD SANITARY CORPORATION

ter and are just long enough and wide enough to hold uniforms which have been folded once through the center lengthwise and twice crosswise.

These envelopes are 32 inches long and 15 inches wide. They are bound with a ½-inch white bias fold which gives a binding of a quarter inch around the outer edges. This binding adds the necessary firmness to hold the envelope in shape, as well as a bit of trimness in the appearance of the bundle. They are fastened by two large snap fasteners. The name of the student is written on a piece of white muslin and stitched on the envelope. As the members of a class graduate, the names are taken off and others put on. These envelopes are shown in the picture of the linen push cart, ready to be delivered to the nurses' dormitories.

Our noiseproof waste cans drew forth a compliment recently when a visitor was being taken through the hospital. These waste cans have home-made rubber rims and although they are not a hundred per cent noiseless yet, the effort we have made has proved helpful in reducing noise. Each can has a rim of rubber hose fastened around the bottom and a small piece on each handle. The 27-gallon can requires 57 inches of hose. This is split and fitted around the edge of the bottom and fastened to the rim with 6 or 8 small rivets. A medium grade hose costing $0.10¾ per foot is used. This rim lasts from eighteen to twenty-four months.

Two men are responsible for the washing of our windows, walls, doors and transoms. They have a schedule by which they work. A daily record of their actual work is kept and it reflects the advantage of good team work. For example the record for the month of April which carried twenty-six working days shows: 923 windows washed, walls, transoms, doors, electric light shades—112½ hours. Of our 722 windows, some are washed on a weekly schedule, some bi-monthly, some monthly. It is interesting to note how the cost in this unit of the housekeeping plan is affected by weather changes. In the early days of spring when the screens are down, the men race along washing windows at the rate of five cents per window; when the screens are in, this cost increases to seven or eight cents and the same is true of window washing in the winter. When the weather is quite cold, their work is confined to walls and wood work.

The duties of all workers in the housekeeping department are closely coordinated. Great stress is placed on efficiency, but greater stress on efficiency with quietness. To this end each work schedule has the following note at the bottom:

"Every possible precaution must be used to avoid unnecessary noise in or about the hospital. Use special care in handling cleaning equipment and in opening and closing doors. Make quietness a habit, and in doing so you will contribute to the welfare of our patients and to the reputation of our hospital."

Miniature Room Contest Announced by NEHA

If your housekeeper wanders about with small slips of colored paper in her hands and a far away look in her eyes, do not begin to worry. She will merely be planning her miniature room for the NEHA contest on room decoration.

The purpose of the contest, which is open to all NEHA members, is to show skill in interior decoration by constructing and furnishing a complete miniature model room — bedroom, suite, living room, dining room, bath, kitchenette, or any room a contestant may wish. Hospital rooms may be submitted by hospital members of the association. All work in the room must be original, save for the furniture, and if that is made by a carpenter or upholsterer, for example, its design must be original with the housekeeper submitting it. However, it may be purchased outright, in this case originality is not a requirement.

Miniature models may be any size, although a scale of one inch to the foot has been suggested. The floor, and two or three walls must be shown. These may be made of plywood or building board. The amount of furniture and the number of windows are optional.

The first prize is $50 in cash; the second, tuition and accommodations (exclusive of transportation) for a week's course in housekeeping management at a college which has a summer course in this subject; third, a complete housekeepers' library.

Fuller information on the contest may be obtained from Anne Owens and Crete Dahl, co-chairmen of the association's education committee.

Rugs and Carpets

Rugs and carpets should be of uniform size to permit interchangeability while they are being cleaned. They should be of a size to permit ease of handling. The latter factor facilitates frequent quarter turning to lessen wear in any portion. A daily thorough vacuum cleaning and periodical reconditioning by commercial cleaning firms seems to be the best means of assuring cleanliness and long service. Small scatter rugs in cheerful colors may be used in patients' rooms.

THE HOUSEKEEPER'S CORNER

• In a small room built into one corner of the Hotel Sherman's mezzanine floor, which was the temporary property of the 250 exhibitors of the Illinois Hotel Association convention, the housekeepers of Chicago demonstrated their taste in interiors and their grace as hostesses. Restful blues, creams and reds were incorporated into the room's color plan, and informal flower arrangements as well as comfortable chairs made it a delightful place in which to rest. Tea was served here in the afternoons during the convention which opened March 23.

• Mrs. Adele B. Frey, Hotel Hollenden, Cleveland, addressed the housekeepers at their formal meeting on Thursday afternoon on "The Housekeeper in her Relation to the Other Departments of the Hotel."

• The NEHA Commentator, which Mrs. Alta M. LaBelle, executive housekeeper, Michael Reese Hospital, edits for the Chicago chapter, was kept at the booth for distribution. The March issue carried the convention program and the address of Mrs. Marion Wyatt who is president of the Chicago chapter.

• MRS. MARTHA E. WOLFE, executive housekeeper at the Presbyterian Hospital, Chicago, resigned on March 1, after twenty-five years of service in that hospital's housekeeping department. BERNICE STEIN is now in charge of the housekeeping department.

• The selection of personnel for the hospital's housekeeping department is particularly difficult. Jane VanNess, executive housekeeper, has developed several standards she uses in selecting her help. For instance, she will ask the applicant to raise a window or pick up a vase and put it down on a table across the room. When this is being done, she notices the assurance and deftness with which the applicant moves. If she does these things easily, quickly and with confidence, she is given a chance at further tests. If she walks awkwardly or uses her hands clumsily, she may get no further than the first interview. According to *Hotel Monthly*, if the applicant passes these and similar tests, she is not hired immediately, but given an opportunity to work on trial for a few days with no assurance that she will be hired permanently. During the trial period, the applicant is further observed, and if she seems to meet the necessary requirements she is accepted for permanent employment.

• That spot on the wallpaper that won't come off with your ordinary wallpaper cleaner may be oil or grease. Mix tetrachloride with fuller's earth to a soft paste. Apply to the stain a quarter of an inch thick. When it is dry, brush off. The spot will usually come with it.

HERE IS ANOTHER REASON WHY *Linoleum* FLOORS OFFER YOU EXTRA CLEANLINESS

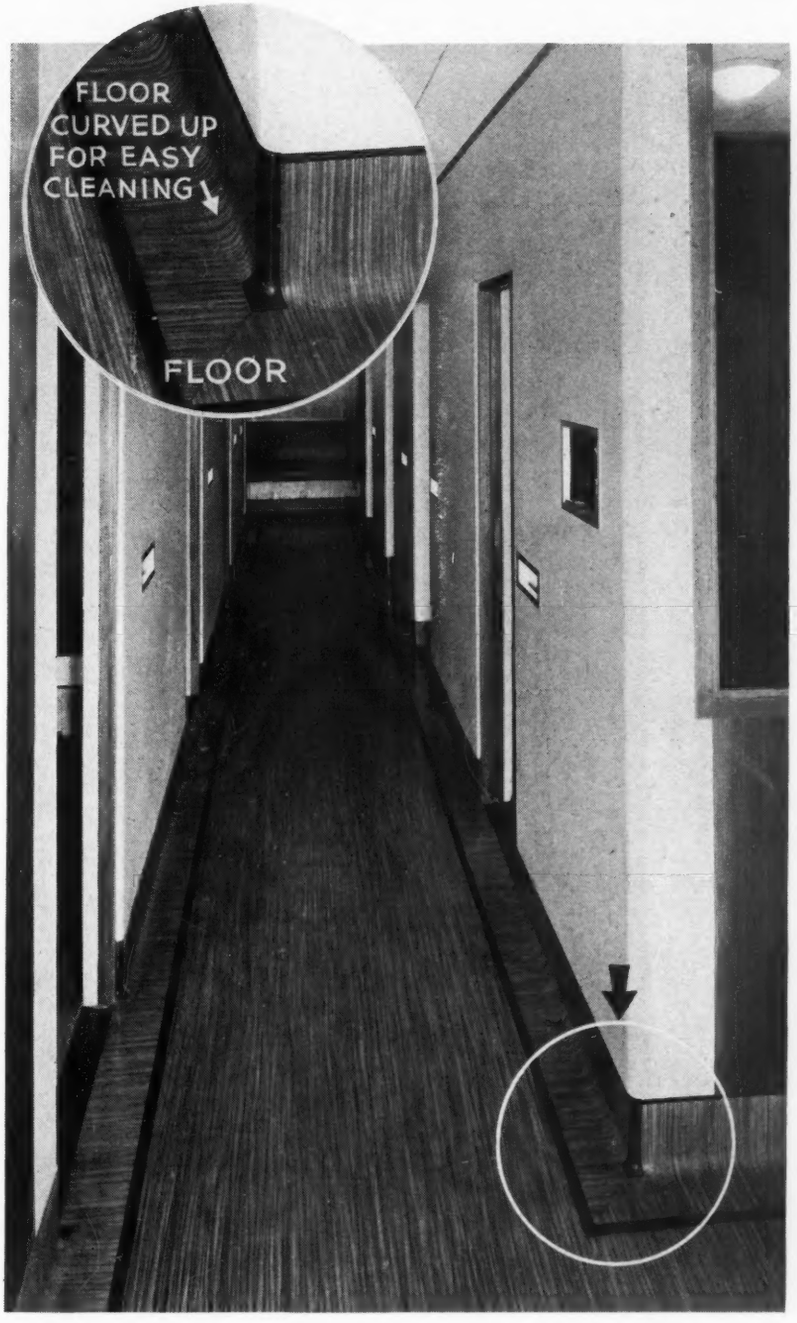
YOUR hospital will be more sanitary and more attractive when Armstrong's Linoleum Floors are installed with the new type of cove-and-base shown in the circle at the right.

This device permits the floor linoleum to be curved up the wall—forming a rounded, seamless joining that prevents the accumulation of dust and dirt. Because sharp angles are eliminated, sweeping is easier, faster, and more thorough.

Leading hospitals are adopting this new type of linoleum floor construction with Armstrong's Flash Type Cove and Base. It can be installed in old buildings as well as new. If you already have linoleum floors, this aid to sanitation can be added quickly and at small expense.

In addition to cleanliness, Armstrong's Linoleum offers hospitals other important advantages. It is cheerful in coloring. It is durable. It is restful and quiet underfoot. And it is economical to maintain by daily dusting, occasional washing, and waxing with Armstrong's Linogloss Wax.

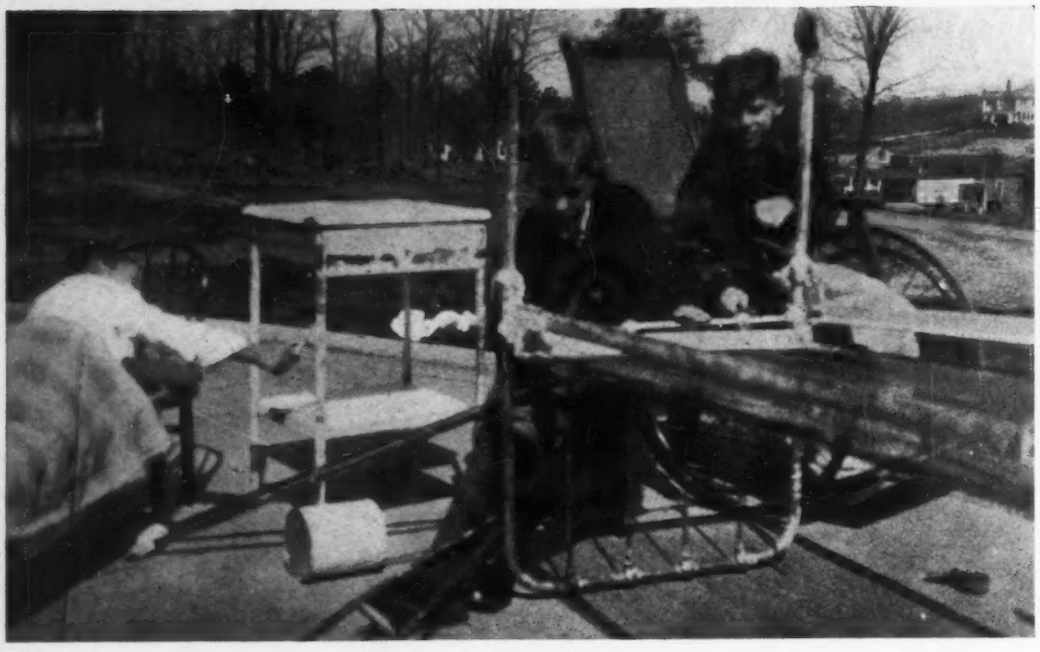
For hospitals, Armstrong manufactures the only complete line of resilient floors—Linoleum, Rubber Tile, Cork Tile, Linotile, and Accotile. Write now for suggestions and a color-illustrated copy of "Better Floors." Armstrong Cork Products Company, Building Materials Division, 1210 State Street, Lancaster, Pennsylvania.



In the offices of Drs. Hosford and Hicks, Los Angeles, Armstrong's Gray Jaspe Linoleum floors are used with Armstrong's Flash Type Cove and Base. This device forms a seamless, curved joining of floors and walls. It makes sweeping easier and prevents dirt from collecting. (See details in large circle.) Walls here are Armstrong's Travertine Linowall—a washable, linoleum-type wall covering.

ARMSTRONG'S *Linoleum* *and* RESILIENT TILE FLOORS

LINOTILE · ACCOTILE · CORK TILE · RUBBER TILE · LINOWALL · ACOUSTICAL CEILINGS



It is fun for the children to knock the paint off the beds, get the furniture ready for painting. The lower picture shows the finished job.

For the Cost of the Paint

By Helen McGrath

THE occupational therapy department of the North Carolina Orthopedic Hospital, Gastonia, is frequently called upon to do the odd jobs for which others have neither time nor inclination. During spring cleaning the director was asked to supervise the painting of some half-dozen beds, the enamel of which had become chipped. As sometimes happens in an orthopedic hospital, there were many ambulatory patients in walking casts or on crutches, waiting for shoes or operations, and it was thought that painting the beds would prove an interesting and profitable method of keeping the older children occupied.

The fact that she had no previous experience in painting did not prevent the director from beginning the work, and needless to say the children were only too glad to help. The first relay of beds were touched up as suggested but the results were far from satisfactory. The beds looked spotty and rough. It was then decided to scrape off all the enamel and do a real paint job. This was rather difficult for amateurs but when it was accomplished the beds looked so nice and the children were so enthused that finally permission was given for scraping and repainting all the beds.

Children who were able to hold a file or hammer were allowed to help in the cleaning and later with the painting. Each morning when the beds were taken out in the sun the hammers were distributed. The noise was then deafening for several hours, but the children thought it great fun. Enamel flew like scattered snow flakes. As only a few beds could be painted at one time, for these had to be temporarily exchanged for others, there was a race to see who could get his bed cleaned first.

One child, whose bed was badly scarred, bargained with his bed-fellows for help so as to get his bed cleaned first. Often four to six children would be working on the same bed. When all the enamel had been removed and the bed thoroughly sandpapered, it was taken to the basement room of a near-by building where the children painted it.

Sometimes the first coat was put on outside. Each bed required three coats of flat white and one coat of enamel to give the necessary smooth, shiny surface. Eventually forty-four single beds and twenty-two baby cribs were cleaned, sandpapered and painted, as were twelve metal bedside tables, two nurses' desks, six ward chairs and two large tray holders.

Splendid cooperation was evidenced at all times during the four months required for the work. It was hard work, for it caused many blistered hands, but it was eagerly and cheerfully done by children on crutches or in wheel chairs. Those in bed did much of the cleaning and sandpapering. The active working groups changed almost weekly as the children had operations or went home, others taking their places with the paint brushes. Each group quickly learned the necessary details and took great pride in getting a smooth surface.

All were delighted with the nice appearance of the ward when the painting was finished and the children were more careful not to get the furniture soiled or marred. Many talked about how they would paint the furniture at home. Best of all was the lesson that each child learned through practical experiences — "that any thing that is worth doing at all is worth doing well."

FOOD SERVICE

Conducted by Anna E. Boller, Rush Medical College

Dietitians in the Diabetic Clinic

By Anna E. Boller and Alice Royston

A medical student clerk showing patient's mother the technique of insulin injection. Patients then do this at home.

THE diabetic clinic is one of the many clinics served by the dietitians at the Central Free Dispensary of Rush Medical College, Chicago. In addition, they serve actively in the neurology and pediatric departments and plan diets for patients referred from all the other clinics. This paper will cover only the work in the diabetic clinic.

There are, at present, 1,229 diabetic patients registered in the diabetic clinic, 15 per cent of whom are taking insulin; twenty-nine of these are children. The average clinic attendance is forty-eight.

The diabetic clinic is held every Thursday morning from nine to twelve o'clock, under the supervision of Dr. Leo K. Campbell. The staff consists of five doctors; three clerks, who are senior students at Rush Medical College; a student nurse from Presbyterian Hospital school of nursing; two dietitians, and from three to six diabetic "children." These so-called "children" are young diabetic patients who work in the clinic in return for their insulin and insulin equipment. More will be said about them later.

Each patient, after registering, is weighed and has his pulse and temperature taken by the student nurse. He brings with him a sample from the previous day's twenty-four-hour specimen of urine, which immediately is sent to the laboratory to be analyzed. The urines are analyzed qualitatively for sugar (Haines solution), for aceto-acetic acid and for acetone. As results are obtained, they are recorded on the patient's chart along with the weight, pulse and temperature and then the charts are given to the dietitian.

She interviews each patient and ascertains and records on the metabolic sheet the volume of the twenty-four-hour specimen of urine, and whether or not the patient has been adhering to his diet. If he has, the carbohydrate, protein, fat, calorie and glucose values of the diet are also recorded. If the patient has not kept his diet, this is indicated.

CHECK ON EDUCATIONAL WORK

I. Preliminary Instructions:
   - A. Diet
     1. Use of scale and metric system.
     2. Food groups.
     3. Reading of diet.
     4. Use of saccharine.
   - B. Urinalysis
     1. Collection of twenty-four-hour specimen.
     2. Test for sugar.

II. General Information:
   - A. Diabetes
     1. Glucose.
     2. Tolerance.
     3. Glycosuria.
        a. Cause.
        b. Why it should be stopped.
        c. How it is stopped.
   - B. Diet
     1. Substitutions.
     2. Desugarizing diet.
   - C. Urinalysis
     1. Aceto-acetic acid.
        a. Cause.
        b. Test.
        c. What to do if it is found.

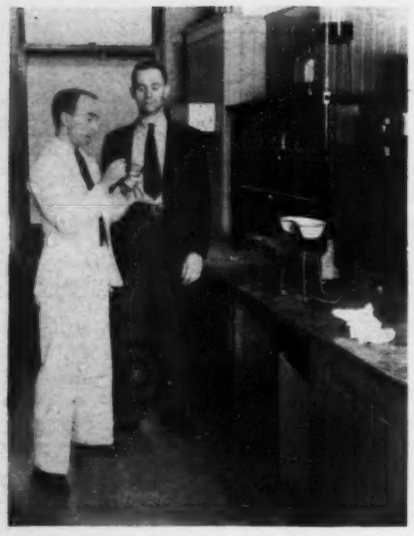
III. Necessary Information for Insulin Patients:
   - A. Technique of Injection
   - B. Insulin
     1. What it is.
     2. What to do if supply is exhausted.
   - C. Reactions
     1. What they are.
     2. How to relieve them.
     3. Sugar on person.
   - D. Emergency Program
     1. Management.
     2. When to start it.
     3. Review aceto-acetic acid test.

IV. Equipment—Patient has purchased:
   - A. Diet
     1. Notebook.
     2. Scales.
   - B. Urine Testing Outfit
     1. Haines solution.
     2. Ferric chloride.
     3. Test tubes.
     4. Dropper (marked).
   - C. Insulin Equipment
     1. Syringe and needles.
     2. Insulin.

The amount of insulin taken daily is recorded in doses, for example, 16-0-8, listed in the insulin column would indicate that the patient was taking 16 units of U 40 insulin before breakfast, none at noon, and 8 units before supper. If protamine insulin is taken in addition to regular insulin, the protamine is recorded in red figures and the regular insulin in black. The charts are then ready to go to the doctors.

Each patient is assigned to a doctor on his first visit and is seen by that

Miss Royston is seen instructing a patient in weighing her diet. At the other table a man is being shown how to measure diet by servings. The lower picture shows a medical student instructing a diabetic patient in the technique of urinalysis.



doctor in his own examining room each time he returns to the clinic. A new patient is given a complete physical examination and his history is taken by one of the clerks. After completing these, the clerk confers with the staff doctor to whom the patient has been assigned. A decision is reached as to what treatment the patient is to be given, depending upon the apparent severity of the case.

One of the following types of treatment is ordered:

1. Desugarizing diet—for older and apparently mild cases. The diet consists of a basal replacement diet, that is, just what the body would burn of itself during starvation, namely, 0.5 grams of protein and 2.0-2.3 grams of fat per kilogram body weight.

2. Maintenance diet with insulin—for obviously severe cases.

3. Emergency program — for patients in an acidosis. (Explained in detail later.)

4. Test diets—for patients with no history of diabetes in the family and no symptoms other than glycosuria. These diets produce in the body 200, 300 and 400 grams of glucose respectively. Patients are placed on each diet for three days. At the end of each three-day period, they bring in a sample of each twenty-four-hour specimen for a careful analysis which includes quantitative sugar, polariscopic and fermentation tests. Starvation blood sugars are taken. At the end of this study the diagnosis is made.

If the patient has any disorder in addition to his diabetes he is referred to the clinic treating such condition. An appointment is made with the dietitian to have each patient return to her for dietary and treatment instructions. Whenever the emergency program is ordered, complete educational work is given immediately rather than at a later appointment.

All educational work is given individually to patients on appointment. Medical clerks are instructed in the various procedures and assist the dietitians in educating the patients.

The accompanying outline is the basis of all educational work. The amount given varies with the mental equipment of the patient and the severity of his diabetes. New patients are all taught the contents of I-A and B and II-A and given a notebook and urine analysis equipment. The notebook is small in size (4½ by 7 inches), and has a cardboard cover on the inside of which is printed the 5 per cent, 10 per cent, 15 per cent and 20 per cent groups of fruits and vegetables. Two sheets containing general instructions for diabetics are included, with a dated copy of the patient's diet prescribed by the doctor.

If the patient is not on insulin, the diet is given in servings. The size of these is explained to him with the help of wax models of food, the following being typical: 100 grams of fruits and vegetables; 200 grams of milk; 10 grams of butter; 20 grams of bread; 150 grams of meat; 20 grams of bacon.

Urinalysis is taught using a dropper marked at 1 c.c. for measuring. The proportions are 5 c.c. of Haines solution to 2 c.c. of urine.

New insulin patients are given complete information as listed in the outline, with the exception of the "emergency program." Syringes, needles, and scales are sold or given by the dietitian. Insulin and alcohol are obtained from the drug department. Each patient is given a small dose of insulin after receiving his educational training, as a final check to determine whether or not he understands the injection procedure.

In the beginning, new patients return to the clinic once a week until their tolerance is determined and their diabetes is in balance. This is required whether they are insulin or non-insulin patients. After this has been accomplished and they have been trained to manage their own cases, they do not need to report oftener than once every three months unless unusual circumstances arise. They are, of course, at liberty to return as often as they wish. If they do not return after a three-months' period, appointment cards are sent to them urging them to attend clinic for a check-up.

In this clinic, U 40 insulin is used exclusively. Pay patients, of course, purchase all their equipment at standard price. Relief clients are furnished their equipment, which is partially covered in the Relief's payment to the dispensary. Dr. George W. DuVall, the superintendent, has placed the full responsibility for the giving of insulin and insulin equipment on the dietary department.

Each year several hundred dollars is supplied by a friend of the clinic, so that patients financially unable to purchase insulin, who need it immediately but are not receiving charity, can be supplied until some satisfactory permanent arrangement for obtaining it can be made. Last year $2,968.50 worth of insulin was given out by the dispensary, either to relief clients or from the special fund.

It has already been explained when the "emergency program" is necessary. The purpose of this program is to enable patients to clear up an acidosis before it becomes serious enough to

FOR THE ACID ASH DIET . . . Tomato-Mushroom Sauce with Noodles. Melt butter, add flour and cook slightly. Add Libby's Tomato Juice and allow to thicken. Add diced mushrooms and serve hot over buttered noodles or spaghetti.

FOR THE HIGH CALORIC DIET . . . Tomato Aspic with Salmon Salad. Fill a ring mold with aspic made with Libby's Tomato Juice. Turn out on lettuce and fill center with salad made with Libby's Red Alaska Salmon. Garnish with sliced hard-cooked egg.

Libby's gentle press

(PROCESS PATENTED U. S. 1,956,615)

TOMATO JUICE

A popular and dependable source of Vitamin C

ACCEPTED AMERICAN MEDICAL ASSN. Council on Foods

● It's pleasant to know that Libby's Tomato Juice—the kind whose *gentle press* flavor has made it so widely popular—is also a *dependably* excellent source of Vitamin C. ● Tomato juices are by no means alike in their content of this essential vitamin. The quality of the tomatoes, and the speed and skill with which they are handled make a notable difference. ● Libby's Tomato Juice is made from vine-ripened, unblemished fruit by a patented process that guards against oxidation. It contains Vitamins A, B, C and G; can be confidently chosen as an excellent source of Vitamin C. ● Naturally you'll serve Libby's Tomato Juice most often as a refreshing drink and for the High Vitamin Diet. However, it has many interesting uses in other special diets, as shown here.

FOR THE HIGH CALCIUM DIET . . . Tomato-Rarebit and Bacon. Melt equal amounts of butter and flour (2 tbsps.), mix well, add ¾ c. cream. When mixture thickens, add ¾ c. Libby's Tomato Juice mixed with pinch of soda, 2 c. diced cheese, 2 eggs slightly beaten, and seasoning. When cheese melts, serve on rusks or toast with a strip of crisp bacon.

● *Libby's 100 Fine Foods include Fruits and Fruit Juices, Vegetables, Pickles, Condiments, Canned Meats, Evaporated Milk, Alaska Salmon. Each comes in regular and special sizes for institutions. In addition, Libby packs Homogenized Foods for Babies.*

No. 78840

CENTRAL FREE DISPENSARY
RUSH MEDICAL COLLEGE
CHICAGO

METABOLISM DEPARTMENT

NAME L—, A— METABOLIC RECORD DR. F—

1937 DATE	WEIGHT	PULSE	TEMP.	DIET C	P	F	CALORIES	G	URINE VOLUME	SUGAR	ACET.	A. A.	ALB.	BLOOD SUGAR	INSULIN
JAN 28	108 8	100	98.8	RESTRICTED STARCH					SINGLE	++++	0	0			
FEB	106 7	84	97.6	35	54	123	1463	75	1920	Tr.	0	0			
FEB 11	1049	88	98.6	35	54	123	1463	75	1440	0	0	0			
FEB 18	1024	80	98	45	52	91	1207	84	1920	0	0	0			
MAR 4	1022	82	97.4	66	61	90	1318	100	1920	0	0	0			

A typical example of a patient's chart.

require hospitalization. The method of accomplishing this is to shorten the period of observation from twenty-four to six hours. In other words, the patient takes insulin and food (milk) every six hours. Each six-hour specimen of urine is tested for sugar, and the insulin dose is raised as needed. The advantage of this procedure is that the insulin is so rapidly increased that cases of acidosis not yet comatose may be brought under control in a few hours—seldom do they require over twenty-four hours.

A new patient in an acidosis condition is given complete educational work regarding the weighing of the diet, the injection of the insulin and the urine-testing procedure for acid and sugar. He is given a dose of insulin while still at the clinic, and the covering feeding of milk. He is sent home with his insulin and equipment, with directions for the ensuing eighteen hours, given the clinic phone number and the dietitian's home phone number. He reports by phone every six to eight hours and reports back to the clinic the next morning with a sample of the last specimen. In this way very close track is kept of patients on the emergency program. The next day directions are given for the following day, when the patient is asked to report again.

After patients have been attending the clinic for a month or two, and their diabetes is in balance, they return for a check-up on the previous educational work, and are given the explanations under II-B and III. Most patients now are ready to take care of themselves with regular visits to the clinic only every three months.

The "diabetic children," mentioned above, form an ever increasing, ever changing group. They are young diabetics ranging in age from fifteen to twenty-seven years. They have been patients in the clinic from one to twelve years. They run the laboratory tests, assist the student nurse, and record her reports and the urinalysis reports on the patient's records. Aside from helping with the routine in the diabetic clinic, they are encouraged to assist as a therapeutic measure.

When a young person is discovered to have diabetes, his case is generally a severe one requiring insulin. These facts are something of a shock, not only to the child but also to his parents. He soon finds that he is different from other children, that he can't eat as promiscuously as other children of his own age. He must eat all of his meals at home under his mother's exacting care and jurisdiction. Everytime he tries to do things as his friends do them, he is told "Don't" by a watchful parent. His life gradually becomes unbearable—an everybody "don'ting" existence, unless something is done.

That something is getting him in contact with other young diabetics. Just letting him learn that there are others like himself who have been living along for some time rather normally makes a tremendous difference, as he soon finds that he can manage as nicely as the others do. He will learn that by using a little discretion, he does not have to weigh every mouthful of food he eats, if his diabetes is not too brittle; he may even vary the contents of his meals, instead of having the same stated amount of the foods prescribed. Gradually his diabetes will be pushed back in his mind, and normal interests will take its place.

One of the greatest aids in bringing about this readjustment to normal life is the lunch which is planned, prepared and served by these "diabetic children" after the clinic. As this is all done in the dietetic department kitchen and dining nook, it takes on the air of a party where the absence of all formality makes possible a free exchange of ideas and offers an opportunity for the staff to do a little educational work.

Protamine insulin is now being used in the department. The transition from regular insulin to protamine has been somewhat slow, for only one patient at a time can be taken into the hospital and it takes about five days to transfer each patient to the new insulin. However, this is being done as rapidly as possible.

How the Trade Blends Coffee

Faith McAuley, state administrative dietitian of the Illinois Emergency Relief Commission, in a recent article entitled "How the Trade Blends Coffee," explains the method and reasons for the blending of coffee.

She tells that coffee is a plant native to the tropical plateau and its producing regions encircle the globe. It is a relatively new product not having been widely used before 1855, and the consumption was doubled in each of the two following thirty-year periods and again during prohibition. Brazil is the center of coffee production today instead of Mocha and Java from which previously coffee was heavily imported into the United States.

Our coffee now comes principally from South America, Central America and Mexico. The blending of coffee is a common practice although certain coffees are excellent straight, but in blending four or five different coffees special needs can be met and a more uniform product maintained. Miss McAuley says:

"Blending then is practiced because it enables the dealer to maintain trade standards; to control the price, the coffees in a blend being used of the kind and in the amount to meet a desired price; to meet special trade demands. It is also through blending that the dealer secures for his coffee the special 'cup quality' desired.

"In blending for cup quality certain characteristics are selected as score points to be used in judging the sample brew prepared from each coffee to be tested. Thus coffees are judged for flavor, thickness or body, acidity or life, holding quality and for style or perfection of bean.

"Flavor is the most important of these characteristics. The flavor and aroma in coffee are due to the aromatic oils which are developed by roasting, and which are quite volatile. Roasting is therefore an important process requiring expert judgment acquired through long practice. Roasting not only develops flavor but renders the berry brittle so that it grinds easily. During roasting a loss in weight of 12 to 23 per cent occurs, the amount depending on the degree of roast. The so-called acid coffees like Mocha and the Mexicans are easily damaged by too high roasting. A high roast destroys the flavor and results in a bitter tasting product. 'High roasted' coffees produce a brew which gives the impression of being strong and so are much used in commercial service.

"The most acceptable flavor is developed by a medium roast. A light roast gives a weak coffee, the volatile oils not being well developed."

Gelatinized Milk

SCORES IN

INFANT FEEDING TESTS

A preliminary study conducted in the Department of Pediatrics of a prominent Eastern University was made with three groups of infants (fifty babies in each). The study was intended to duplicate the usual type case as seen by the practicing physician such as vomiting, constipation, and other disorders relating to the digestive system.

To determine any differences between cow's milk, lactic acid milk, and gelatinized milk* was the purpose. The results as reported (Archives of Pediatrics January-February 1937) are:

1. **Infants fed gelatinized milk appeared to be less susceptible to infections, especially upper respiratory infections, than those fed acidified or cow's milk.**
2. **The occurrence of diarrhea was less frequent in the gelatinized milk group and acidified milk group than in the plain milk group.**
3. **The group of infants fed gelatinized milk had a better rate of gain than those groups fed acidified milk or plain cow's milk.**
4. **Vomiting and "appetite poor" symptoms among the infants were obviated or showed improvements when fed gelatinized milk in contrast to the feeding results of the other groups which showed little change.**
5. **The infants in the gelatinized milk group had more favorable results than the acidified milk group or cow's milk group in relation to constipation.**

* [One or two per cent of Knox Gelatine was added to the formula water which had been boiled and cooled. The gelatine was softened ten minutes before being added to the milk of the formula.]

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KNOX GELATINE LABORATORIES
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Kindly send me a copy of above-mentioned report. Include a sample of Knox Gelatine for me to try.

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Food Served With Finesse

By Elizabeth Hayward

IN TOO many institutions food is still prepared and served as if eating were only a minor incident in a patient's hospital life. Some of it is prepared by student nurses who are not even average cooks, and much of it is served in a fashion and at an hour that do not suit the taste or convenience of average persons.

Hotel service may be introduced into the average institution at a cost which will permit dividends both in financial return and good will.

Hostelries have become world famous because of their food. Elaborate restaurants may open with the fanfare of movie premières and run along on momentum for a while, but only good food can keep them open. The way to get a crowd out to a sewing circle or a Sunday school picnic or a musical tea is to promise them food. When people tell of a visit to a foreign country, the first thing they mention is usually food.

One cannot but agree that most people live to eat. A universal weakness for food and the needs of that special group of patients who must eat to live—what a chance these give the dietitian.

Fortunately, many institutions have lightened the burdens of food administrators by abandoning or modifying their student nurse training programs. Firstclass service to a discriminating clientele is often incompatible with an educational program. One or the other must be subordinated. It has been found in many cases much better to build up a permanent employee personnel and organize all service to the end that patients may be pleased and benefited.

Las Encinas Sanitarium, Pasadena, Calif., is an outstanding example of the smaller institutions that have led in the trend toward a more modern hospital service. The dietitian has absolute control of the dietetic department, doing all the purchasing, employing all the help, performing many duties as a hostess and supervising the housekeeping department. She takes a personal interest in each guest and fits the type of service to the individual need. Menus are selective or selected by the dietitian. The ideal of the department is to combine the finest food service with the most scientific nutritional values.

The cooks, all women, prepare the food in a wholesome way, with the home-cooked appeal that only women can give. All special diets are served in the same manner as other diets and prepared by the same excellent cooks.

No large group of individuals could be pleased with one set menu and it is doubly hard to satisfy a group of sick and nervous patients. For this reason a carefully planned selective menu is imperative in giving a service which will meet individual needs and tastes. A selective menu system can be introduced into a small hospital at a surprisingly low cost.

It is possible to get a head tray girl who can type, cut stencils and operate a mimeograph machine for the usual pay of around $50 a month. A mimeograph machine will cost from $35 up. One stencil may be used for the reproduction of two days' menus if a printed form, about 8½ by 9 inches is employed with the regulation legal size stencil, utilizing the top half one day and the bottom the next. A little practice on the part of both typist and dietitian will enable them to fit the menu to the space available and still leave room for the printed headings above the three columns, one for each meal of the day, separated by perforations.

Good judgment on the part of the dietitian is essential in order to have a menu which will fill the needs of all classes of patients, from those on general diet to those requiring or entitled to special diet. Without watchfulness, costs may easily increase disproportionately, but with the exercise of care and judgment, the improved service outweighs increase in costs.

Las Encinas maintains a patients'

The patients' dining room at Las Encinas Sanitarium, Pasadena, Calif.

dining room where 35 to 50 per cent of the patients have at least one meal a day. A definite effort is made to arrange congenial groups. High quality linen, sterling silver, goblets, flowers and other appointments of the well ordered dining table lend a pleasing atmosphere. Small institutions which are desirous of attracting the better class of ambulatory patients for relatively long stays should not overlook the advantages of having an attractive dining room where meals can be eaten in the most cheerful and natural surroundings.

Full-time waitresses may be employed, or where the amount of work in the dining room and kitchen does not warrant that, girls working in the housekeeping department may be used for the required hours as dining room waitresses. In the latter case it is advisable to employ young inexperienced girls and train them for their various duties.

Meal Hours Must Be Flexible

Meal hours must be reasonably flexible, offering the patient a latitude of choice to suit his customary routine. Since breakfast is the high point of the day for many patients of widely varying habits, freshly prepared breakfasts should be available for both dining room and tray service from 7:00 to 9:30. The lunch period need not be so extended, or the dinner period, so long as they are late enough.

Dining room atmosphere should be maintained in rendering tray service, especially to ambulatory patients who may not choose to come to the dining room. Bed patients with their usual bed tray present no problem, but ambulatory patients who dine in their rooms should not be expected to eat in cramped quarters off chairs or writing tables. Suitable tables for service, even if only card tables, should be provided, and chairs of the proper height for the patient and any guests he may have. Much will have been done for this class of patient if his tray service is conducive to a proper frame of mind for dining.

If an attempt is made to serve a full meal, from soup to dessert, all at one time, good service cannot be rendered. Since centralized food service is the standard in hospitals, the problem can be solved only by the use of individual hot food conveyors. The perfect tray set-up consists of all hot drinks in thermos jugs, all frozen desserts in ice packs, other cold food on cold plates, and hot food, other than the first course, in a hot food conveyor. The breakfast tray should be set with all cold food; hot drink and cereal, and the eggs and bacon, ham or other hot dish, with the rolls or toast, should be in a hot food conveyor. The dinner tray should be set with all cold food, drink and soup, the entreé and vegetables being delivered in a conveyor. Properly instructed tray boys will experience no difficulty in carrying out this plan of service.

There has been much discussion regarding the comparative cost of the use of linen and paper tray service. Las Encinas uses the best grade linen damask tray cloths and napkins. An accurate record for the past five years has been kept of replacements and laundry cost for both tray and dining room service. The average monthly replacement of linen, including that used in both patient and employee dining rooms, is $36, and the laundry monthly average is $136.60. It is possible to buy linen tray cloths, 19 by 25 inches which just fit the standard hospital tray, for between $5 and $6 a dozen. Careful buying and close checking are necessary to hold down linen expense to a reasonable figure, but the effect of good linen on the tone of service makes this worth the effort.

The nourishment kitchen may give service out of the ordinary if an intelligent, courteous, attractive girl is put in charge. All between-meal nourishments come from this kitchen, and there is no reason why these should not be comparable to the best obtainable anywhere. Tea, cakes, beer when prescribed, fruit drinks, refreshments for small impromptu parties, should be available to patients from this kitchen at all reasonable hours for a reasonable fee. Las Encinas has found that patients are greatly pleased by having their birthdays remembered, and from this kitchen go out decorated birthday cakes for the patients' entertainment of friends or fellow patients. By these small festivities many long afternoons are made pleasant.

Two Kitchens Are Used

Las Encinas operates two kitchens, one for the preparation of patients' food and one for employees'. A separate kitchen where employees' food is prepared reduces the food volume which must be prepared in the main kitchen, with a consequent improvement in the quality of many dishes which are not well adapted to quantity cooking. The operation of two kitchens instead of one presents some obvious disadvantages, but these have been found in some instances to be more than offset by gains. With separate kitchens it is much easier to segregate food for patients and employees, and this is an item which increases in importance as the quality of patients' food is improved.

This is in no sense to be taken as a recommendation for poor food for nurses and other employees. Such a policy is short-sighted and against the ultimate welfare of all concerned. Work in a hospital or sanitarium is hard and exacting. A corps of well trained, efficient employees, in order to be more or less permanent, must be well fed. Institutions with the least amount of costly labor turnover are not indifferent to the health and happiness of their employees for the sake of the few dollars which may be pinched from their food bill. A sanitarium should not try to make money as a boarding house for employees and special nurses whose board is paid by patients. This is not a legitimate source of revenue, and profiteering in this department can well dry up sources of legitimate profit.

The Question of Costs

Costs of this catering service are somewhat higher than the usual meal costs reported. During the year 1936 Las Encinas food cost per patient per day averaged $1.73, the low for any month being $1.57, the high $2. Labor was $0.64 per patient per day; replacements, including linen, dishes and miscellaneous equipment replacements not charged to assets, was $0.16, making a total dietary department direct cost of $2.53 per patient per day. Meal costs by actual count, including patients, staff and all employees for the year 1936, averaged for food $0.258, labor $0.098 and replacements $0.24, or a total direct cost per meal of $0.38.

These figures may be higher than the average required for satisfactory food service. Much depends upon general conditions and location with respect to markets. In "grading up" the quality of her food service, the dietitian will often find that she must reeducate her superintendent on the matter of costs. She will have to convince him that an increased percentage of patients' fees allotted to food service will pay real dividends.

In improving institutional food service much depends upon the dietitian. Instead of merely being ashamed of the justifiably bad reputation for quality, preparation and service which institutional food now bears, it is possible for many administrative dietitians to bring about a gradual reorganization of their departments, without disrupting routine or incurring great expense, if they will just plan and work intelligently to that end. Many institutions have a number of more or less permanent patients, or patients who should return from time to time for long periods, because of chronic conditions. Many people who are not actually ill enough to go to a hospital for surgical or acute cases, but who cannot be properly cared for at home, need institutional service.

Erase some of the present connotations of that word "institutional" from the popular mind, and many persons will seek the professional care they should have. It is possible for a dietitian of initiative and vision so to improve her department that it will be an important factor in bringing this about, to the advantage of both the patient and the institution.

Hospitals find greater benefits from this nutritious food supplement

ROUTINE NOURISHMENT—Ovaltine is more than just a good-tasting drink. It brings greater benefits than the usual hospital beverage. It contains nourishing and protective food elements in an easily digested and readily utilized form, which impose no undue burden on rundown patients. It is palatable and adds variety to the hospital diet.

MEALTIME BEVERAGE—Ovaltine is a welcome alternate at mealtime when coffee and tea are contraindicated. By increasing palatability and digestibility, Ovaltine encourages the consumption of milk. It also adds to the caloric content of the meal without increasing bulk.

SPECIAL DIETS—Ovaltine has proved valuable as a food supplement in the diet of convalescents, undernourished children, expectant and nursing mothers and post-operative cases. It is particularly adaptable to liquid and semi-liquid diets where appetite and digestion are handicapped.

• • •

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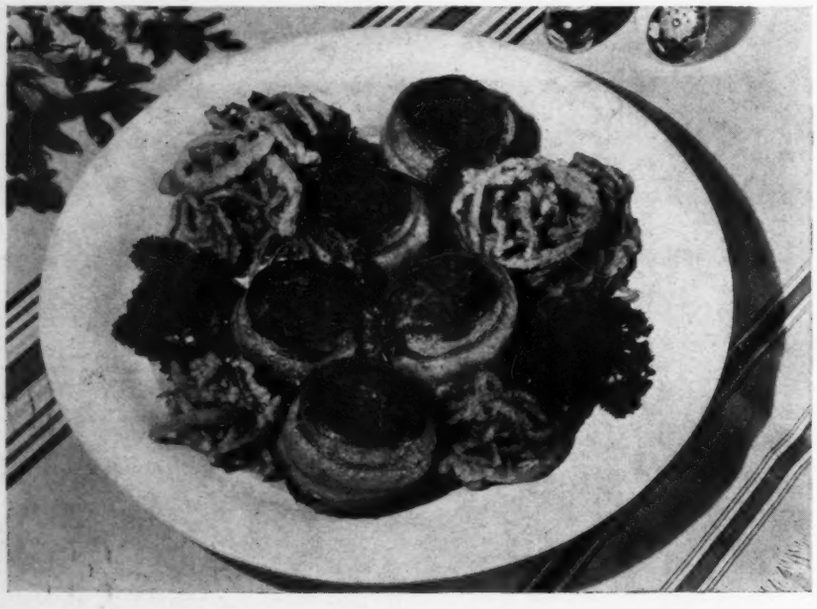
May Day Tray

Consommé; squab; potatoes; peas; grapefruit, orange, pear salad (Shircliffe's); chocolate ice cream; coffee.—*Mary Edna Golder, chief dietitian, St. Anne's Hospital, Chicago.*

Liver Patties



1½ lbs. liver
2 c. cracker crumbs
4 tbsp. bacon drippings
⅛ tsp. marjoram
1 small onion, grated
1 tsp. salt
¼ tsp. pepper

Parboil liver and put through the food chopper. Combine with cracker crumbs, grated onion, bacon drippings and seasonings. Moisten with hot water and shape into thick patties. Wrap with slices of bacon and fasten with a toothpick. Place in the broiler to cook the bacon and reheat and brown the liver, or brown in bacon drippings in a hot skillet. Serve with French fried onion rings, prepared as follows: Slice mild onions into thick slices. Separate into rings. Dip in milk and fry in deep hot lard until they are golden brown. Serve at once.

FOOD FOR THOUGHT

• Grace Carden of Strong Memorial Hospital, Rochester, N. Y., reports that guests of patients on the private floor are served meals at $1 per meal. The request for this meal comes from the nurse to the dietary department, the nurse sending a charge slip through to the cashier's office to be put on the patient's bill.

• At the meeting of the Southern Medical Association in Kansas City, Dr. Hugh L. Dwyer discussed the importance of giving a diabetic child a practically normal diet. He stated that children eating such a diet get along better, need less insulin and have fewer complications, such as coma and insulin shock. In a normal child's diet, the total calories are made up approximately as follows: carbohydrate 50 per cent, protein 15 per cent, and fat 35 per cent. Diabetic children will usually do well on such a diet as they are more cooperative.

• A notation has just been received from a doctor on some research work that is being conducted on the use of a drug which will have the same effect as the ketogenic diet, introduced by Clark and Helmholz of the Mayo Clinic in 1931 as a treatment for certain types of infection of the urinary tract. The following comments are made about this drug:

"Variations in tolerance among different patients to this diet and the impossibility of sufficiently reducing the pH of the urine in some patients have led to research for an adjunct to this treatment which would enhance the efficacy of the diet and reduce disturbing side reactions.

"Among the drugs now being studied for this purpose, mandelic acid has proved highly beneficial in a carefully controlled clinical series of cases. Originally introduced by Rosenheim, it has been used both as the sodium salt (sodium mandelate) combined with the administration of ammonium chloride, and as ammonium mandelate, obviating the simultaneous administration of ammonium chloride in many cases.

"We are reliably informed that research laboratories are cooperating with a limited number of clinical groups in the study of this new agent for increasing urinary acidity and the bacteriostatic and bactericidal power of the urine. In many cases it has been found unnecessary to continue the ketogenic diet in view of the beneficial results which can be obtained by the use of ammonium mandelate alone."

• A new booklet, "The Story of Oranges and Lemons," should be interesting to all dietitians, as it gives the early history of the citrus fruit industry and considerable information about the California fruits.

VITAMIN REQUIREMENTS OF MAN

II. VITAMIN D

• The quantity of vitamin D required by an individual is influenced by such factors as environment, race, age, mineral content of the diet, and possibly by the source of the vitamin. Deficiency is manifest in children as rickets and decreased calcium retention, and in adults by the less well defined condition known as osteomalacia.

The minimum daily intake which will prevent rickets in infants is probably between 135 and 400 International units of vitamin D as supplied by cod liver oil (1). The optimum prophylactic dose is probably in the neighborhood of 1000 International units (2). It is also interesting to note that the League of Nations Technical Commission has recommended a daily intake of 340 International units of vitamin D for pregnant and lactating women (3).

Irradiated pasteurized milk containing 135 International units per quart and irradiated evaporated milk of the same potency have been found equally effective in preventing rickets in infants. The pediatrician will be interested in the following summary taken from a recent review:

> "Such evidence as is available may be interpreted to show that cod liver oil, cod liver oil concentrate milk, and irradiated milk are of equal potency for the human being, unit for unit." (1-b).

Other than the above recommendation for vitamin D intake during pregnancy and lactation (3), little definite information is available upon which to establish minimum vitamin D requirements of the human after infancy (1), yet while sunlight produces the anti-rachitic factor, most common foods are known to be deficient with respect to vitamin D (4). However, certain foods such as eggs, butter, liver and sea foods do supply this vitamin. The importance of sea foods, especially canned salmon, as carriers of vitamin D has been definitely established. A recent report on the vitamin D content of different varieties of canned salmon gave a value of 1.9 International units per gram for the least potent brand and 6 or more units per gram for several other brands (5).

From a consideration of the vitamin D values of salmon oil, the oil content of canned salmon and the quantity of canned salmon consumed annually in this country, it has been concluded that there is more vitamin D in the canned salmon sold in this country than in the cod liver oil used for both human and animal feeding (6).

Although neither the minimal nor optimal requirements of individuals of different ages are definitely known, the values of evaporated milk fortified with vitamin D and of canned sea foods as sources of this important vitamin, are well established.

AMERICAN CAN COMPANY

230 Park Avenue, New York City

(1) a. 1937. J. Am. Med. Assn. 108, 206
b. 1936. Ibid. 106, 2150
(2) 1936. J. Am. Diet. Assn. 11, 503
(3) 1936. League of Nations Report on Physiological Bases of Nutrition, League of Nations Publication Department, Geneva.
(4) 1935. J. Am. Diet. Assn. 11, 119
(5) 1935. J. Home Econ. 27, 658
(6) 1931. Ind. Eng. Chem. 23, 1066

This is the twenty-third in a series of monthly articles, which will summarize, for your convenience, the conclusions about canned foods which authorities in nutritional research have reached. We want to make this series valuable to you, and so we ask your help. Will you tell us on a post card addressed to the American Can Company, New York, N. Y., what phases of canned foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles.

The Seal of Acceptance denotes that the statements in this advertisement are acceptable to the Council on Foods of the American Medical Association.

May Breakfast and Supper Menus

By Doris T. Odle

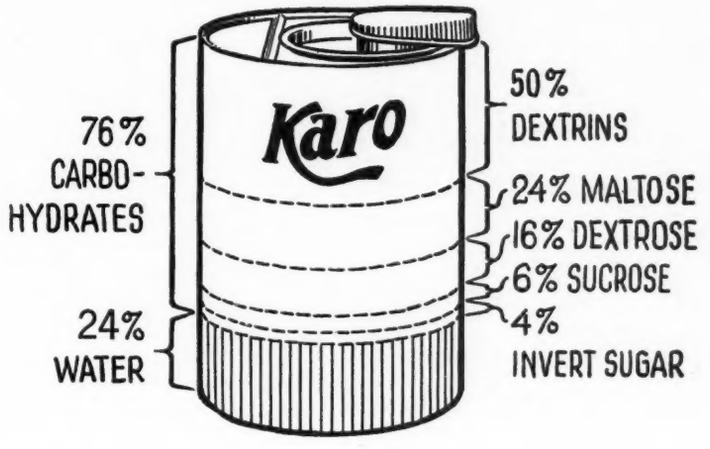
Dietitian, Presbyterian Hospital, Denver

	BREAKFAST		SUPPER				
Day	Fruit	Main Dish	Soup or Appetizer	Main Dish	Potatoes or Substitute	Salad or Relish	Dessert
1.	Tomato Juice	Scrambled Eggs With Bacon	Grapefruit Cocktail	Chop Suey	Boiled Rice	Lettuce, Thousand Island Dressing	Fruit Cup
2.	Apricots	French Toast With Syrup	Cream of Potato Soup	Cheese Soufflé	Stewed Tomatoes	Spiced Peach	Lemon Tarts
3.	Plums	Breakfast Sausage	Barley Broth	Cold Boiled Ham	Creamed Potatoes	Coleslaw	Pineapple Sundae
4.	Applesauce	Shirred Eggs	Cream of Asparagus Soup	Assorted Sandwiches		Orange, Date and Nut Salad	Float
5.	Pears	Coffee Cake	Corn Chowder	Baked Hash	Buttered Parsley Potatoes	Persian Fruit	Prune Whip
6.	Fruit Cup	Bacon	Consommé	Lima Beans	Celery Creole	Grapefruit in Lime Gelatin Salad	Spice Cup Cake
7.	Sliced Orange	Bran Muffins, Strawberry Preserves	Cream of Carrot Soup	Escalloped Salmon	French Fried Potatoes	Combination Vegetable Salad	Applesauce Cookie
8.	Sliced Banana in Orange Juice	Creamed Chipped Beef	Split Pea Soup	Asparagus Tips on Toast	Stewed Tomatoes	Banana Salad	Glorified Rice
9.	Sliced Peaches	Egg Omelet	Tomato Juice	Sausage	Fried Apples	Grated Carrot and Raisin Salad	Chocolate Cake
10.	Fresh Pineapple	Cinnamon Toast		Thick Chicken Noodle Soup	Spinach With Sliced Lemon	Perfection Salad	Date Torte
11.	Prune Juice	Fried Mush With Syrup	Clam Chowder	Creamed Sweet Breads in Patty Shells	Buttered Parsley	Bohemian Pineapple	Tapioca Marvel
12.	Grapes	Bacon	Cream of Celery Soup	Wiener Sandwiches		Mixed Fruit Salad	Peach Pie
13.	Sliced Orange	Soft Boiled Egg	Navy Bean Soup	Italienne Spaghetti		Spiced Pear	Black Walnut Ice Cream
14.	Plums	Pineapple Muffins With Jelly	Consommé With Noodles	Cottage Cheese Salad	Baked Potato and Buttered Peas		Cottage Pudding With Sauce
15.	Frozen Strawberries	Egg Nests	Vegetable Soup	Escalloped Tuna Fish	Cauliflower	Stuffed Celery	Maplenut Mold
16.	Pineapple Juice	Grilled Ham	Cream of Mushroom Soup	Individual Chicken Pie	Wax Beans	Orange and Grapefruit Salad, French Dressing	Brown Apple Betty
17.	Figs	Sweet Cinnamon Rolls	Pineapple Juice	Creamed Dried Beef on Toast	Harvard Beets	Shredded Lettuce	Chocolate Pudding
18.	Pears	Breakfast Sausage	Rice Broth	Corned Beef Hash with Poached Egg	Peas and Carrots	Pear With Cottage Cheese Salad	Lemon Snow
19.	Apricots	French Toast With Syrup	Cream of Tomato Soup	Welsh Rabbit	Baked Potato	Combination Vegetable Salad	Youngberry Pie
20.	Tomato Juice	Bacon	Consommé	Hamburger in Bun		Pineapple Waldorf Salad	Orange Sherbet
21.	Prunes	French Toast With Preserves	Tomato Bouillon	Creamed Eggs and Mushrooms on Toast	Green Beans	Coleslaw	Apple Pie
22.	Sliced Orange	Buckwheat Cakes With Syrup	Corn Chowder	Baked Beans	Asparagus	Olives and Radishes	Peach Meringue
23.	Fresh Pineapple	Scrambled Eggs	Broth With Noodles	Macaroni With Cheese	Carrots	Lettuce, French Dressing	Hot Chocolate, Oatmeal Cookies
24.	Orange Juice	Coffee Cake	Fruit Punch	Lamb Chops	Julienne Potatoes	Tomato Aspic	Butterscotch Pie
25.	Grapefruit	Poached Egg on Toast	Fruit Cocktail	Escalloped Potatoes With Ham	Stewed Tomatoes	Peas, Celery and Cheese Salad	Coconut Cake
26.	Sliced Banana	Fried Ham	Cream of Corn Soup	Assorted Cold Meats	Baked Potato	Pickle Chips	Orange Bavarian Cream
27.	Frozen Strawberries	Bacon	Tomato Juice	Chili Con Carne		Sunflower Salad	Cherry Cobbler
28.	Fruit Cup	Soft Boiled Egg	Vegetable Soup	Cheese Fondue	Harvard Beets	Apricot With Cottage Cheese Salad	Chocolate Shower Ice Cream
29.	Grapefruit	Coffee Cake	Cream of Mushroom Soup	Spanish Corn	Mashed Turnips	Asparagus Salad, French Dressing	Banana Cake
30.	Applesauce	Cinnamon Toast	Navy Bean Soup	Toasted Bacon and Tomato Sandwich		Gingerale Gelatin Salad	Baked Apple
31.	Pineapple Juice	Poached Egg on Toast	Clam Chowder	Creamed Chicken on Biscuit	Mashed Potatoes	Pickled Beets	Graham Cracker Pudding

Recipes will be supplied on request by Anna E. Boller, The MODERN HOSPITAL, Chicago. Space precludes listing of cereals, breads and beverages. Several varieties of well known cereals are always offered for breakfast.

In Infant Feeding

THE DOCTOR IS CONCERNED ABOUT THE COMPOSITION OF A MILK-MODIFIER!



WHEN you prescribe Karo as the milk-modifier you are providing well-tolerated, readily digested maltose-dextrins-dextrose. The dextrins are practically non-fermentable; the maltose rapidly transformed to dextrose requiring no digestion; the sucrose added for flavor is digested to monosaccharides. Karo is prepared chemically and bacteriologically safe—non-allergic, practically free from protein, fat and ash.

★ Infant feeding practice is primarily the concern of the physician, therefore, Karo for infant feeding is advertised to the Medical Profession exclusively.

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Write CORN PRODUCTS SALES COMPANY, Dept.-H-4, 17 Battery Place, New York, N. Y.

NEWS IN REVIEW . . . .

Hospitals and Unions Generally Adopt a "Let's Talk It Over" Attitude

Labor difficulties in hospitals flared sporadically in the New York metropolitan area last month and negotiations looking toward a citywide agreement were begun in Seattle.

A sit-down strike was staged by seventy-five maintenance employees of the Hospital for Joint Diseases, New York City, who on March 8 barricaded themselves in kitchen and laundry. A conference was immediately called at the home of Dr. J. J. Golub, administrator of the hospital, at which hospital officials met officials of the union. Dr. S. S. Goldwater, commissioner of hospitals, was present as an "interested observer."

Throughout this dispute the statements issued by hospital officials to the press were temperate and conciliatory. Louis J. Vorhaus, attorney for the hospital, was quoted in the *New York Times*, for example, as follows: "This strike was unnecessarily precipitated. We are desirous of reaching an understanding. We have given a letter recognizing the union as the agent for the employees who belong to it. We will notify the union not later than 11:00 a.m. tomorrow if we can meet its demands. There will be no lockout of strikers."

Terms of Settlement

The strike was settled within twenty-four hours. Terms of the settlement were as follows:

1. The hospital negotiated with the union provided that the strike was called off immediately.
2. The union was recognized as representing its members.
3. The hospital preserved liberty to employ union or nonunion maintenance employees and to hire, discharge or transfer maintenance employees at will.
4. The hospital's decision with respect to discharges and transfers is final but the hospital is willing to give the union a hearing on any complaint without obligation to alter the decision.
5. Minimum salaries of $50 for employees living in and $60 for employees living out were agreed upon, but a contract is to be negotiated for a fourteen months' period covering all major aspects of employment. In addition a 5 per cent increase was granted for all maintenance employees earning $60 or more.
6. All personnel practices, such as vacations, sick leave, hours, are to remain as heretofore.

A strike at Jewish Hospital, Brooklyn, N. Y., where labor difficulties have been simmering for some time, resulted in violence, arrest of strikers and the charging of employees with disorderly conduct and violation of the penal law. On Monday, March 15, 132 maintenance employees staged a sit-down strike barricading themselves in a basement kitchen, the laundry, and in a diet kitchen on an upper floor. Among those involved were maids, cooks, elevator operators, porters and other maintenance employees.

In ousting and arresting the strikers police used drawn revolvers, blackjacks, night sticks, axes, crowbars and an operating table battering ram.

Nineteen employees were arrested on Monday and charged with violating section 1910 of the penal law which makes it a misdemeanor to endanger patients in a hospital through refusal to carry out the terms of a labor contract.

While these employees were awaiting trial, a second strike was staged on Wednesday, March 17. As a result of this strike, thirty-nine employees were arrested and sixty-three were discharged for striking.

When the police arrived each striker was asked whether he was willing to return to work. Those answering affirmatively were sent back to work. Those saying "No" were asked whether they would leave the building peaceably. Those who still said "No" were arrested forthwith.

The strikers were arraigned before Magistrate Mark Rudich who told them that hospital employees "can't quit on a moment's notice any more than a fireman can quit when a building is burning." He added that if the strikers had only a slight spark of the philanthropic desires that actuated the hospital officers they would not resort to such tactics but would be more considerate of the patients.

At the time of going to press, Fred Gardiner, organizer of the Hospital Employees' Union, and Morris Berlin, vice president, stated that another strike would soon be called in Jewish Hospital to force the reinstatement of over 100 employees discharged for striking. The trustees, however, disregarded the threat and decided not to reemploy those engaged in the sit-down strike. The Hospital Conference of the City of New York also, by unanimous resolution, condemned the sit-down strike as a weapon of labor warfare in hospitals and commended the Jewish Hospital for refusing to countenance it.

An amicable settlement of a wage dispute at Beth Israel Hospital, New York City, was reached on March 17 without any strike. Following several weeks' negotiation between the hospital and representatives of the employees, a substantial wage increase was made for 400 employees. Terms as published were:

Minimum monthly compensation of $60 for all employees now receiving from $45 to $50; minimum of $62.50 for all receiving from $51 to $57; a 7½ per cent increase for all employees receiving from $60 to $84 and a 5 per cent increase for all receiving from $85 to $170.

In announcing the increases the Association of Hospital and Medical Professionals, which negotiated for the workers, pointed out that no employee of Beth Israel Hospital has ever been dismissed for union activity.

In Seattle, the local of the Building Service Employees International Union demanded wage, hour and working condition adjustments.

At the time of going to press conferences were going on between the hospital council and the labor council in an effort to mediate the differences without violence.

It is independently reported that the union movement in Seattle hospitals did not originate with the hospital employees but is part of a general move, supported by the mayor, to unionize all business activity in the city.

The original demands of the union were as follows:

1. An eight-hour day completed

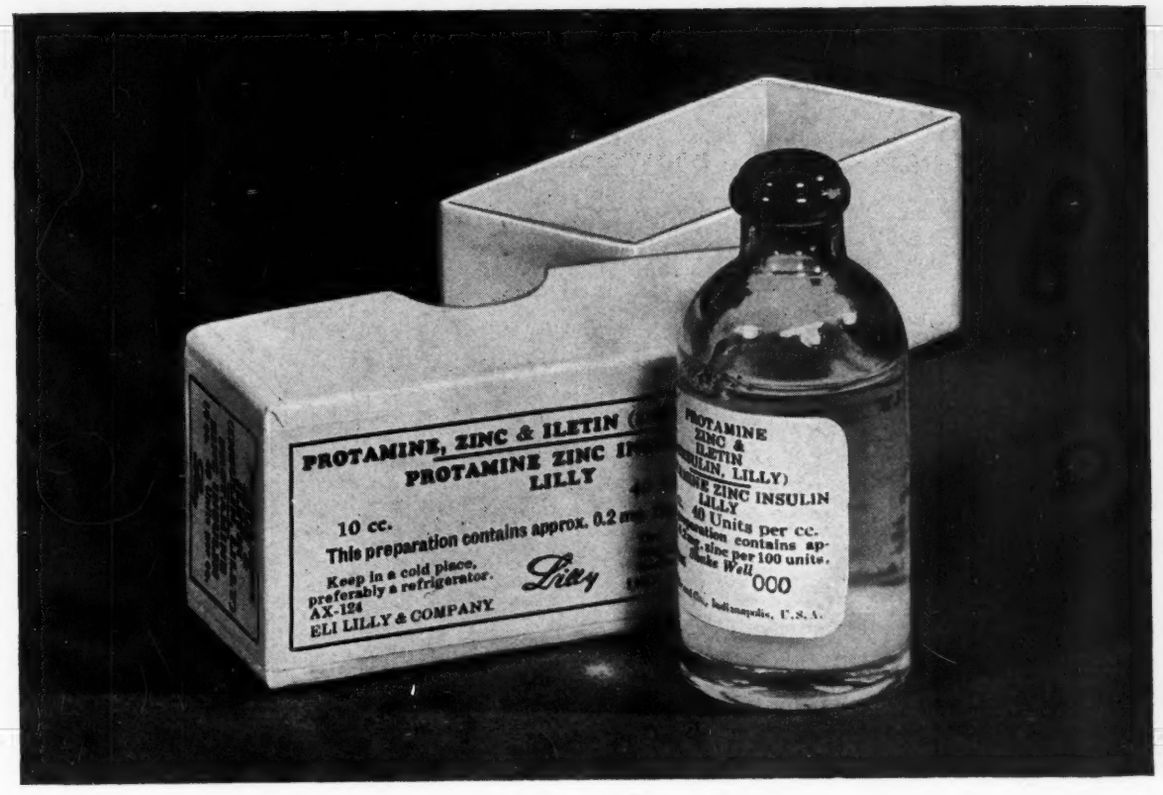
(Continued on page 114)

Blast Opens Hospital One Day Ahead of Schedule

Tragedy stalked the corridors of Mother Francis Hospital at Tyler, Tex., putting an end to all plans for a gala opening.

One day before its scheduled dedicatory services, Mother Francis Hospital hastily opened its doors to receive the children injured in the gas blast at New London. Instead of serving tea and receiving congratulations, the hospital staff quieted frantic parents, eased small children's pain and felt the last pulse of three fatally injured.

On the scheduled program, following the big banquet, Robert Jolly, superintendent of Memorial Hospital, Houston, was to speak on "The Community and the Hospital." However, the community now really knows its hospital.



PROTAMINE, ZINC & ILETIN (INSULIN, LILLY)

PROTAMINE ZINC INSULIN LILLY

PROTAMINE, Zinc & Iletin (Insulin, Lilly) has been developed as a result of co-operation with Dr. H. C. Hagedorn and his associates of Copenhagen, Denmark, and the University of Toronto.

Protamine Zinc Insulin represents a step forward in the management of diabetes and in many cases offers definite advantages over unmodified Insulin in treating the diabetic.

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Census Reveals Overcrowding in Mental Hospitals, Overbuilding in General

In seventy-four state mental hospitals the number of patients hospitalized exceeds the buildings' rated capacities by more than 15 per cent. This was made known by the council on medical education and hospitals of the American Medical Association at the completion of its annual census of registered hospitals.

Out of a total of 247 state mental hospitals only 93 had no excess of daily census over rated capacity. Connecticut, Missouri, Rhode Island and Wisconsin each reported that it has one mental hospital in which the patients exceed by more than 50 per cent the rated capacity of the building. Alabama, California, Colorado, Delaware, Idaho, Kentucky, Maine, Massachusetts, Michigan, New Jersey, Pennsylvania, Oklahoma, Vermont and West Virginia admit to excessive overcrowding in at least one mental hospital; Iowa, in three; Ohio, four.

In all, the statistics showed sixty-one hospitals with less than 15 per cent excess of daily census over rated capacity; forty-six were between 15 and 30 per cent; twenty-four between 30 and 50 per cent, and four above 50 per cent excess. An additional nineteen institutions failed to report both capacity and daily average census.

Hospitals responded with a degree of completeness and accuracy never before obtained in such a survey. The 97 per cent of registered hospitals that responded are representative of more than 99.5 per cent of the hospital capacity in the United States.

Conditions in general hospitals are almost the exact opposite of those in mental institutions. A cursory examination of the reported rated capacity shows a general condition of overbuilding, not overcrowding. General hospitals reported from 30 to 50 per cent of their beds unoccupied. Many have large spaces, whole floors, even entire buildings which have never been furnished. In an editorial in the *Journal of the American Medical Association*, it is suggested that the proper accommodation of some patients with mental diseases and of some with tuberculosis in general hospitals may aid in economic utilization of the oversupply of beds.

During the past year there has been a net increase of more than 20,000 hospital beds. Patients were received for hospital care at the rate of sixteen a minute. The total number reached 8,646,885, and the total patient days were 332,516,856. Babies born in hospitals numbered 831,500.

New York Legislators Study Nurse Practice Act

Two bills to regulate the practice of nursing in New York State are before the legislature at the present time. One, the Esquirol-Stewart Bill, which would place all nurses in two classes, registered nurses and nursing aids, is being sponsored by the New York State Nurses Association. The other, the Feld-Byrne Bill, which would permit practical and trained nurses to practise as now, is sponsored by the National Practical Nurses Association.

The Esquirol-Stewart Bill has two major objectives: (1) to protect the public through the maintenance of safe and efficient nursing standards and (2) to lay down more exactly defined methods for the licensing of nurses qualified to give skilled nursing to critically ill patients and nursing aids who will meet the need for a combination of convalescent or chronic care with some housekeeping duties.

The present nurse practice act, according to the state association has four weaknesses. It fails to define "practice"; it prevents no one from nursing provided the restricted titles of trained, certified, graduate or registered nurse or trained attendant are not used; it lacks enforcement machinery, and its provision for violation is inexplicit. These are all corrected in the proposed bill.

The National Practical Nurses' Association is fighting the bill on the grounds that it would lead to bootleg nursing and that it would throw thousands of trained and practical nurses who would be unable to pass the examinations called for in the bill, out of work, since they would not become nursing aids.

Civil Service Exams for Nurses

Open competitive examinations for the positions of graduate nurse at $1,800, public health nurse at $2,000, graduate nurse (general staff duty) at $1,800, nurse technician (bacteriology, and roentgenology combined) at $1,800, and junior graduate nurse at $1,620 a year, have been announced by the United States Civil Service Commission. The necessary forms and information regarding requirements and duties may be obtained from the Secretary, Board of United States Civil Service Examiners at any firstclass post office or from the commission headquarters in Washington, D. C.

Refer Pennsylvania Group Plan Bills to Committee

Two bills that will provide for the operation of a group hospital insurance plan under the supervision of the state of Pennsylvania have been referred to committee by the General Assembly. The bills should pave the way for launching low cost hospital service throughout the state.

Bill 1754 calls for an amendment to section four of an Act of Assembly, May 5, 1933, so that "corporations (subject by law to the limited supervision of the insurance department) may be incorporated under, and in accordance with, the provisions of this act, for the purpose of establishing, maintaining and operating a nonprofit hospital service plan whereby hospital care and service may be provided to subscribers of such plan by any hospital with which such corporations have a contract for such care and service."

The bill also includes a provision declaring that "a majority of the directors of such corporation must at all times be directors, trustees or administrators of any hospital with which such corporation has a contract for such care and service.

The other bill, 1755, provides for "the regulation by the insurance department of nonprofit corporations organized to provide hospital care and service for subscribers; prescribing legal investments for the funds of such corporations and the hospitals with which such corporations may enter into contracts for hospital care and service; conferring powers on the insurance department and the department of welfare; exempting such corporations from taxation, and providing penalties."

Administrators' Institute Announces Earlier Dates

The Institute for Hospital Administrators is to be held earlier this year because of the advance in dates of the A. H. A. convention. The Institute will open on August 30 and close on September 11, the Saturday just preceding the opening of the convention.

As in previous years it will be held under the auspices of the American Hospital Association on the University of Chicago campus. Mornings will be devoted to lectures and seminars, afternoons to clinics in Chicago hospitals and evenings to round table discussions under the direction of Dr. Malcolm T. MacEachern.

A better integration has been worked out with the Chicago hospitals so as to assure excellent afternoon clinics in administrative procedures. Full information and registration blanks may be obtained by writing the American Hospital Association.

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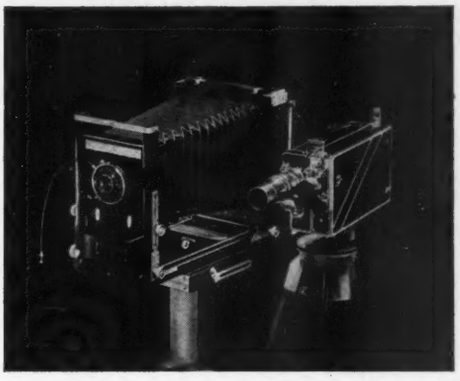

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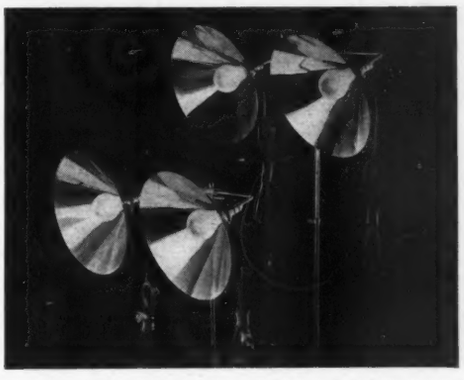

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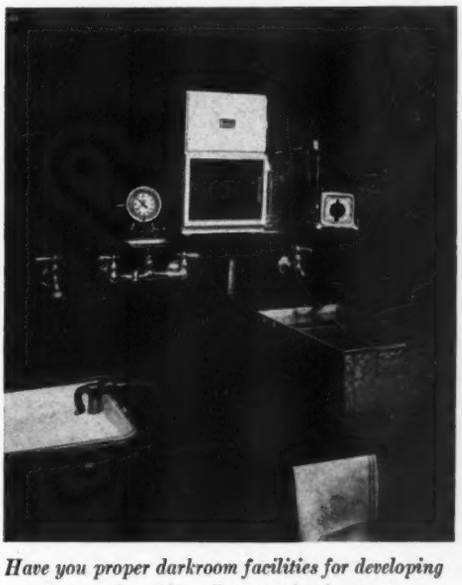

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Southeastern Conference Meets for Full Program

An intensive three days await delegates of the Georgia, Florida and Alabama Hospital Associations to the joint meeting at Atlanta, Ga., April 8 to 10. General business is the order of the first morning, the session closing after a discussion of adequate clinical records in a small hospital by Helen Branham, Ware County Hospital, Waycross, Ga.

Nursing problems take over Thursday afternoon. Lutie C. Leavell, Grady Hospital, Atlanta, will present the new curriculum and explain how it may be adapted by small schools of nursing. Jean Trentham, St. Luke's Hospital, Jacksonville, Fla., will discuss good nursing service and Lucy Harris, Georgia Baptist Hospital, Atlanta, will talk on efficient supervisors.

Dr. Lewis E. Jarrett, hospital division, University of Virginia, will open the Friday meeting with his talk: "What the Hospital Should Do for the House Staff." He will be followed by three Grady Hospital members: Dr. Emory D. Hollar, who will discuss the intern's viewpoint, Mattie J. Ridgway, who will talk on food service in the small hospital and Colvin Wilhite, who will discuss drug service.

The relationship of state and provincial hospital associations to the American Hospital Association will be analyzed by Graham L. Davis, Duke Endowment, at the afternoon session. Alden B. Mills, managing editor, The MODERN HOSPITAL, will discuss a new type of hospital insurance. "The Spirit of the Hospital," by A. M. Calvin, president, American Protestant Hospital Association, will close the formal program. That least pleasant of all hospital administrative problems, the financial, has been saved for last, and Bryce L. Twitty, Baylor University Hospital, Dallas, Tex., Dr. A. M. McCarthy, Electric Mills, Miss., and Dr. A. J. Hockett, Touro Infirmary, New Orleans, will cover the subject Saturday morning. At noon state groups will hold a luncheon for transaction of state business.

Gadgets Capture Interest of New England Delegates

Speakers at the New England Hospital Association convention held in Boston, recently, were faced with some stiff competition for the interest and enthusiasm of their audience. Eighty-six gadgets, performing in a side ring, almost stopped the show, and their presentation, which was the result of thought and effort on the part of Sidney Bergmann, assistant superintendent of Beth Israel Hospital, Boston, may well grow into a bureau of information in research.

Here were all the little practical ideas, crystallized into a practical form and proved by use in the hospital of the inventor—a census board for use on a patient's unit; an indicator to register the whereabouts of an orderly; homemade sharpener for the microtome knife; a chair for spinal punctures; a premature incubator; a device for shaking down a thermometer; a signal device operated by a slight jerk of the head for paralyzed patients; oxygen cylinders, analyzers and canopies.

The entire first day of the meeting was taken up with the subject of maintenance, with emphasis placed upon the advantage of purchasing from responsible firms and upon the standardization of equipment as opposed to the use of custom made. W. L. Kelly reported on a freezing cabinet, now in use at Tarrytown Hospital, Tarrytown, N. Y., which will freeze an alcohol solution in an ice cap to a slush consistency in one and one-half hours and will hold thirty ice caps.

The assignment of one man to watch for fire hazards in a hospital was suggested by Samuel J. Pope, chief of the Boston fire department, who believes that if fire hazards are recognized, fires can be avoided.

An innovation on the program was the introduction of a fracture session presented by four doctors. Here the problem was approached from the need for an understanding of the work of the national and regional fracture committees of the American College of Surgeons and their problems, and from the importance of proper hospital equipment, patient transportation and properly trained personnel. Following this, the group hospitalization program for Massachusetts was reviewed by Dr. Nathaniel W. Faxon, director, Massachusetts General Hospital, Boston.

One of the high lights of the final day's program was a paper, "Ally or Alibi," presented by Phyllis Goodall of the American College of Hospital Administrators, which contained many new ideas on nursing education.

North Carolina Dietitians Meet

Food purchasing took the entire morning at the semi-annual meeting of the North Carolina State Dietetic Association meeting at Winston-Salem recently, when comparative cost of meat cuts and carcasses and wholesale buying of fruits and vegetables were subjects of interest. During the afternoon Dr. E. A. McMillan discussed the effect of nervous influences upon digestion; Cora Gray, head of Cataba College's home economics department, outlined what is new in nutrition; Dr. T. T. Frost spoke on subclinical vitamin deficiencies, and Dr. Eva F. Dodge talked on the subject of proteins in pregnancies.

Coming Meetings

American College of Surgeons.
Sectional Meeting, Denver, April 7-9.

Tri-State Hospital Association (Georgia, Florida, Alabama).
Next meeting, Atlanta, April 8-10.

Western Hospital Association.
Next meeting, Los Angeles, April 12-16.

Ohio Hospital Association.
Next meeting, Columbus, April 13-15.

Michigan Hospital Association.
Next meeting, Ann Arbor, April 15-16.

Tri-State Conference (North Carolina, South Carolina and Virginia).
Next meeting, Raleigh, April 22-24.

Texas Hospital Association.
Next meeting, Lubbock, April 23-24.

Iowa Hospital Association.
Next meeting, Dubuque, April 26-28.

Tri-State Hospital Association (Indiana, Illinois, Wisconsin).
Next meeting, Chicago, May 5-7.

National League of Nursing Education.
Next meeting, Boston, May 9-14.

Mississippi Hospital Association.
Next meeting, Meridian, May 10.

Minnesota Hospital Association.
Next meeting, Rochester, May 13-15.

National Executive Housekeepers' Association.
Next meeting, Cleveland, May 20-22.

Hospital Association of New York State.
Next meeting, New York City, May 20-22.

American Association of Medical Social Workers in conjunction with National Conference of Social Work.
Next meeting, Indianapolis, May 28-29.

New Jersey Hospital Association.
Next meeting, Atlantic City, May 27-29.

Hospital Association of Rhode Island.
Next meeting, Wakefield, June.

Hospital Association of Pennsylvania.
Next meeting, Buck Hill Falls, June 2-4.

Advisory Board for Medical Specialties.
Next meeting, Atlantic City, June 6.

American Medical Association.
Next meeting, Atlantic City, June 7-11.

Mid-West Hospital Association.
Next meeting, Colorado Springs, Colo., June 10-11.

Catholic Hospital Association.
Next meeting, Chicago, June 14-17.

Manitoba Hospital Association.
Next meeting, Brandon, June 24-25.

International Hospital Association.
Next meeting, Paris, July 6-11.

Hospital Association of Nova Scotia and Prince Edward Island.
Next meeting, Sydney, N. S., July 6-7.

National Hospital Association.
Next meeting, St. Louis, Aug. 15-17.

American College of Hospital Administrators.
Next meeting, Atlantic City, Sept. 12-17.

American Hospital Association.
Next meeting, Atlantic City, Sept. 13-18.

American Protestant Hospital Association.
Next meeting, Atlantic City, Sept. 10-12.

Children's Hospital Association.
Next meeting, Atlantic City, Sept. 13-17.

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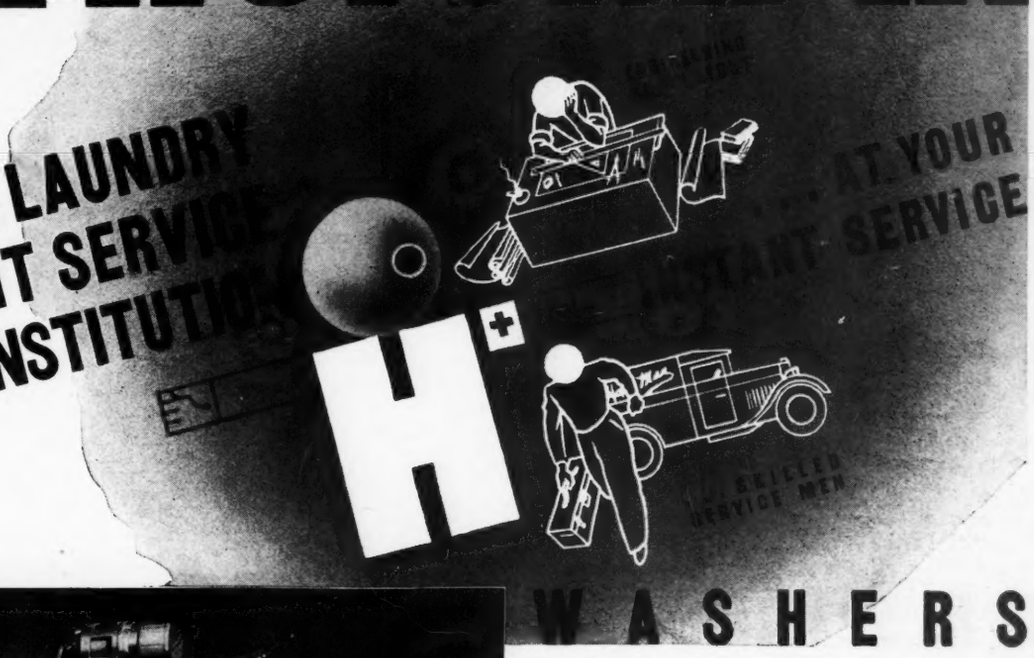

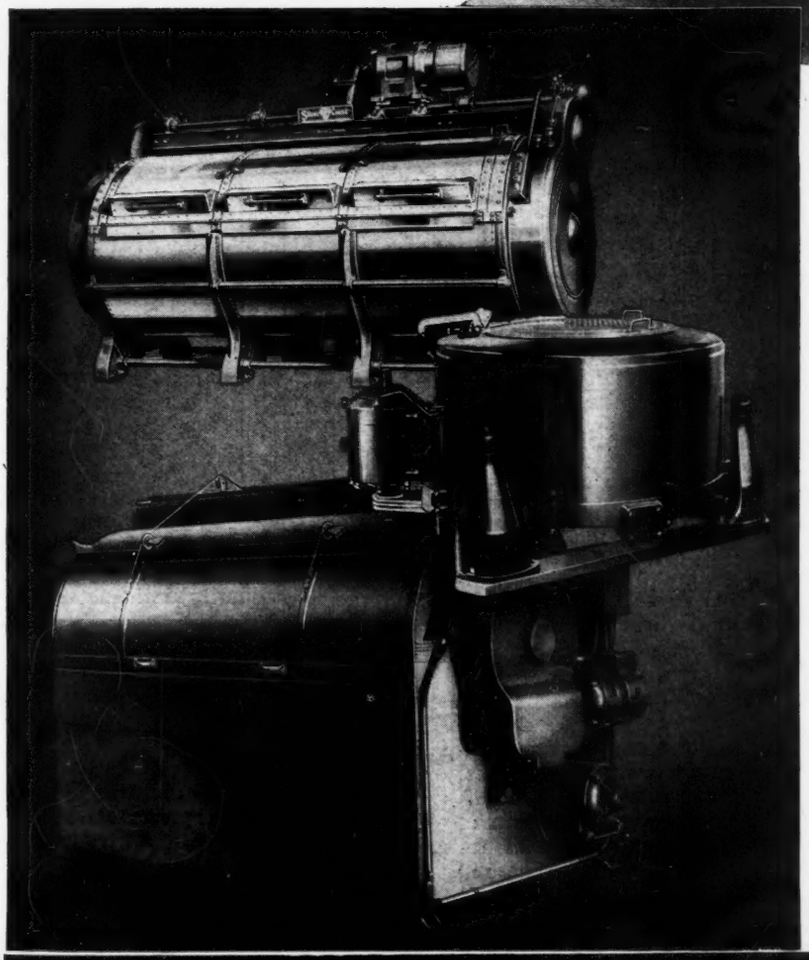

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NEW BUILDING PROJECTS

PHOENIX, ARIZ.—A one-story building, erected on an area 200 feet square, with a patio at its center, will be erected to house the new county hospital to be constructed at the site of the county's home for the aged. Adobe brick will be used for the building, a material that is cheap and heat resisting. When completed, the hospital will accommodate about 200 patients.

SACRAMENTO, CAL.—Every room in the fifty-bed, $110,000 maternity addition to Sutter Hospital will be an outside room and air conditioned, according to present plans for the U-shaped building.

WILMINGTON, DEL. — A four-story, forty-five-bed maternity unit is about to be constructed by Wilmington General Hospital at a cost of about $300,000. Georgian in architecture, to harmonize with the other buildings at the hospital, the new unit will be connected to the main building by solid, enclosed corridors. . . . In addition to the roof garden announced last month for Homeopathic Hospital, two new wings, several additional stories and a second roof garden on the nurses' home are to be erected at the hospital at a cost of between $200,000 and $300,000. The plans call for a four-story wing to the present hospital, a six-story wing to the nurses' home and added stories to the hospital proper and the present home.

WASHINGTON, D. C.—A million dollar hospital, owned and operated by doctors for the use of patients of moderate means, is to be constructed on the lot between the Columbia Medical Building and the Washington Medical Building. To be known officially as Doctors Hospital, Inc., the corporation has been licensed by the state of Virginia. The building will have provision for 250 beds, but is so planned that it may be increased to 400 beds if the demand warrants it.

ANDERSON, IND. — A fourteen-room addition to Hoppes Lying-In Clinic is now under construction. The $6,000 project will provide obstetric accommodations for twelve patients.

BOSTON.—A fifteen-story, $2,000,000 building is to be erected as an addition to Massachusetts General Hospital. The building will be known as the George Robert White Memorial and will be constructed with funds donated by the late Mrs. Harriet Bradbury, Mr. White's sister. It will be used largely for surgical cases.

BROOKLYN, N. Y.—The seventy-five-room addition to the Hospital of the Holy Family will be ready for occupancy this summer. Now under construction, the building, when completed, will cost an estimated $310,000. Fireproof corridors will connect the old and new buildings. The children's ward will be on the first floor of the addition, accommodations for men on the second, and for women on the third and fourth.

HEMPSTEAD, N. Y.—Funds are being raised to provide $500,000 for the erection of a new building for Mercy Hospital. This institution, now thirty years old, occupies a sixty-five-year-old wooden building. The new structure will be on 88 acres of land which the hospital owns and will have a capacity of seventy-five beds. . . . Contracts have been let for a two-story and basement addition to the building for communicable diseases at Meadowbrook Hospital. The architects are the Office of John Russell Pope, New York City.

NORRISTOWN, PA.—July 1 will see the initiation of a building program at Norristown State Hospital to alleviate fire hazards and provide more buildings for the institution. According to an announcement by the State Authority Board, $2,400,000 has been allotted to the hospital for this purpose.

SCRANTON, PA.—A surgical building is being constructed at Moses Taylor Hospital at a cost of $75,000. The building, which is being financed by Mrs. Moses Taylor, daughter-in-law of the founder of the hospital, will be two stories high and will contain three operating rooms, two major and one for eye, ear, nose and throat. The entire building will be air conditioned and soundproofed. An additional $20,000 will be spent on surgical equipment.

EL PASO, TEX.—A combination hospital clinic is being erected at the Rose Gregory Houchen Settlement. It will be one story high with a basement, the basement containing the storage and boiler rooms and two classrooms. The first floor will house the waiting room, two offices, three wards, a semi-private ward, delivery room, labor room, weighing and dressing room, examination and treatment room, dispensary, isolation room, two bedrooms, child's ward, operating room, sterilization room, nursery, utility room and kitchen. The building will be of reenforced concrete, hollow tile and brick construction.

FORT WORTH, TEX. — The cornerstone of the $4,000,000 federal narcotic hospital, six miles southeast of the city, was laid recently by Dr. Walter L. Treadway, assistant surgeon general of the U. S. Public Health Service. The institution will be used to aid noncriminals fight the dope habit. When completed, the hospital will accommodate 1,200 patients, with a total maintenance and operating cost of $600,000 a year.

JACKSON, WYO.—Plans are being drawn for a $75,000, two-story addition to St. John's Hospital which is to be constructed this summer. It will provide a large lobby, two consulting rooms and eight additional bedrooms for the hospital.

Hospitals and Unions Adopt "Let's Talk It Over" Attitude

(Continued from page 108)

when possible in nine hours or in two work periods, all time over eight hours to be paid for at rate of 1½ times hourly rate. A forty-hour week. A thirty-minute lunch period.

2. Minimum wages as follows: maintenance men, $150; assistant maintenance men, $100; head cook, $125; second cook, $100; maids, $75; head orderly, $100; orderlies, $75; linen room attendant, $85; elevator operators, $75; janitors, $90. In addition, all general practices, including provision of meals, now in force are to continue. Part-time work to be paid for at not less than hourly rate of monthly wage. No fines for breakage or loss of equipment. Uniforms to be furnished, when required, by management.

3. Vacations on basis of one day for each month worked, accumulative over a period of one year, provided in June to October, and retroactive to June, 1936.

4. Employees to be protected against sickness and accident either through provision of medical service or of insurance. Compensation to continue during sickness.

5. Union to have right to negotiate for employees. Discharges to be subjected to a hearing before immediate superior with union representative present and with right of appeal to next highest authority until matter is settled.

6. Hospitals reserve right to specify hours during which work is to be performed and how many employees shall do it. Where there is complaint of more work than can be accomplished in eight hours, all work to be reviewed through a committee consisting of the employee, the union representative and the employer.

7. Employees hired by hospital will become union members within 30 days.

8. Union reserves right to act in conjunction with other unions affiliated with Central Labor Council of Seattle whose members may be employed by hospitals.

9. The agreement to be perpetual but subject to cancellation by either party on ninety days' notice.

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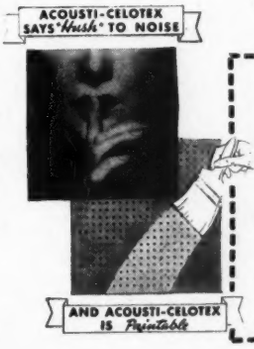

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Varied Program Ready for Tri-State Assembly to Meet in Chicago in May

A program that contains material of distinct interest to hospital administrators, department heads, trustees and members of women's auxiliaries has been arranged for the Tri-State Hospital Assembly, to meet in Chicago on May 5, 6 and 7.

As in past years the mornings will be devoted to general sessions with papers of interest to all participating groups. In the afternoons the various groups will meet separately for intensive discussion of their specialized problems. A trustees' session under the direction of the Chicago Hospital Council is being arranged for the first evening and the annual banquet under the direction of the Chicago Hospital Association for the second evening.

The opening session on Wednesday morning will be devoted to the general theme of administrative organization of the hospital. Fundamentals underlying efficient hospital administration is the first subject for discussion. Departmental organization will be discussed from the following standpoints: nursing department by Janet Fenimore Korngold, St. Luke's Hospital, Chicago; clinical laboratory by Dr. A. S. Giordano, South Bend, Ind., secretary-treasurer, American Society of Clinical Pathologists; x-ray department by Dr. M. J. Hubeny, director, x-ray, Cook County Hospital, Chicago; medical records department by Sister M. Patricia, St. Mary's Hospital, Duluth; dietary department by Lute Troutt, president, American Dietetic Association, Indianapolis, and the medical social service department by a speaker to be selected.

This will be followed by an address on personnel management in the hospital and then a general discussion of the morning's papers to be opened by Edgar Blake, Jr., Methodist Hospital, Gary, Ind.

In the afternoon there will be group conferences for the following groups: medical staff officers, nurses, clinical pathologists, bacteriologists, clinical laboratory technicians, anesthetists, physical therapists, occupational therapists, hospital pharmacists, hospital dietitians, medical records librarians, medical social workers, outpatient clinic directors, hospital accountants, hospital housekeepers, hospital engineers, members of hospital auxiliaries.

At four o'clock on Wednesday there will be short business meetings of the Illinois, Indiana and Wisconsin hospital associations, each meeting separately.

The general theme for the Thursday morning session is maintaining professional service standards. After a general introduction by a nationally known speaker, it will be discussed from the following standpoints: medical staff by Dr. William H. Walsh, Chicago; pathologist by Dr. Harold Dwight Palmer, Rockford, Ill.; radiologist by Dr. Edward L. Jenkinson, St. Luke's Hospital, Chicago, and treasurer, American Roentgen Ray Society; dietitian by Zelia L. Kester, Indianapolis City Hospitals; physical therapist, occupational therapist, nurse and medical social worker by speakers to be selected.

This section of the program will be followed by a general discussion on the application of professional service standards in small hospitals which will be opened by Macie Knapp, Brokaw Hospital, Normal, Ill.

Thursday afternoon will again be devoted to group conferences and the evening to the banquet.

The program on Friday will consist entirely of round table conferences. In the morning the round table for all hospital executives will be led by Dr. R. C. Buerki, president, Wisconsin Hospital Association. Discussion on business methods will be opened by Stewart K. Hummel, Silver Cross Hospital, Joliet, Ill.; on medical staff conferences and pharmacy service by speakers to be announced; on central supply service by Sister M. Margaritis, St. Elizabeth's Hospital, Chicago; on laundry and linen service by Rev. Herm L. Fritschel, Passavant Hospital, Milwaukee; on maintenance by Earl Wolf, Indianapolis City Hospitals, and on public relations by Mrs. E. O. Brown, Brokaw Service League, Normal, Ill.

A luncheon meeting on Friday, the only luncheon scheduled during the assembly, will be sponsored by the presidents and chairmen of all groups participating in the assembly.

The final session will be a round table conference on the problems of small hospitals conducted by Gladys Brandt, Cass County Hospital, Logansport, Ind. Miss Brandt's meeting will deal with maintenance, merchandising, housekeeping, food service, medical staff organization and medical records. Further details regarding this session have not yet been released.

Group Visiting Nursing Discussed in New York

Much interest was evidenced, at a meeting of the Westchester County Hospital Association held in New York City, in a report by Charles F. Neergaard, hospital consultant and chairman of the study committee of the Westchester County, N. Y., conference on group visiting nursing. This conference was organized last November to make a study of the feasibility of financing a visiting nurse service by a method similar to the "Three-Cents-a-Day" plan for financing hospital service.

The object of group visiting nurse service, as Mr. Neergaard pointed out, would be to provide subscribing families at low cost with a generous number of home visits to cases of illness under a doctor's care and to insure the agencies a stable income from a central fund. Its benefits would accrue to families by assuring them visiting nurses' care at minimum cost; to doctors by providing competent home care for a great number of their patients unable to pay for private nurses; to hospitals by releasing beds for acute illness through the earlier discharge of convalescent patients whose condition permits visiting nurse care, and to nurses by enlarging the opportunities for employment by visiting nurse agencies. Efforts are being made to secure necessary financial backing.

Following Mr. Neergaard's discussion of this project current problems in hospital administration were discussed informally. Mrs. Grace McKelvey, superintendent, Yonkers General Hospital, Yonkers, and Mary A. Land, superintendent, Mount Vernon Hospital, Mount Vernon, presided.

Preconvention Conferences

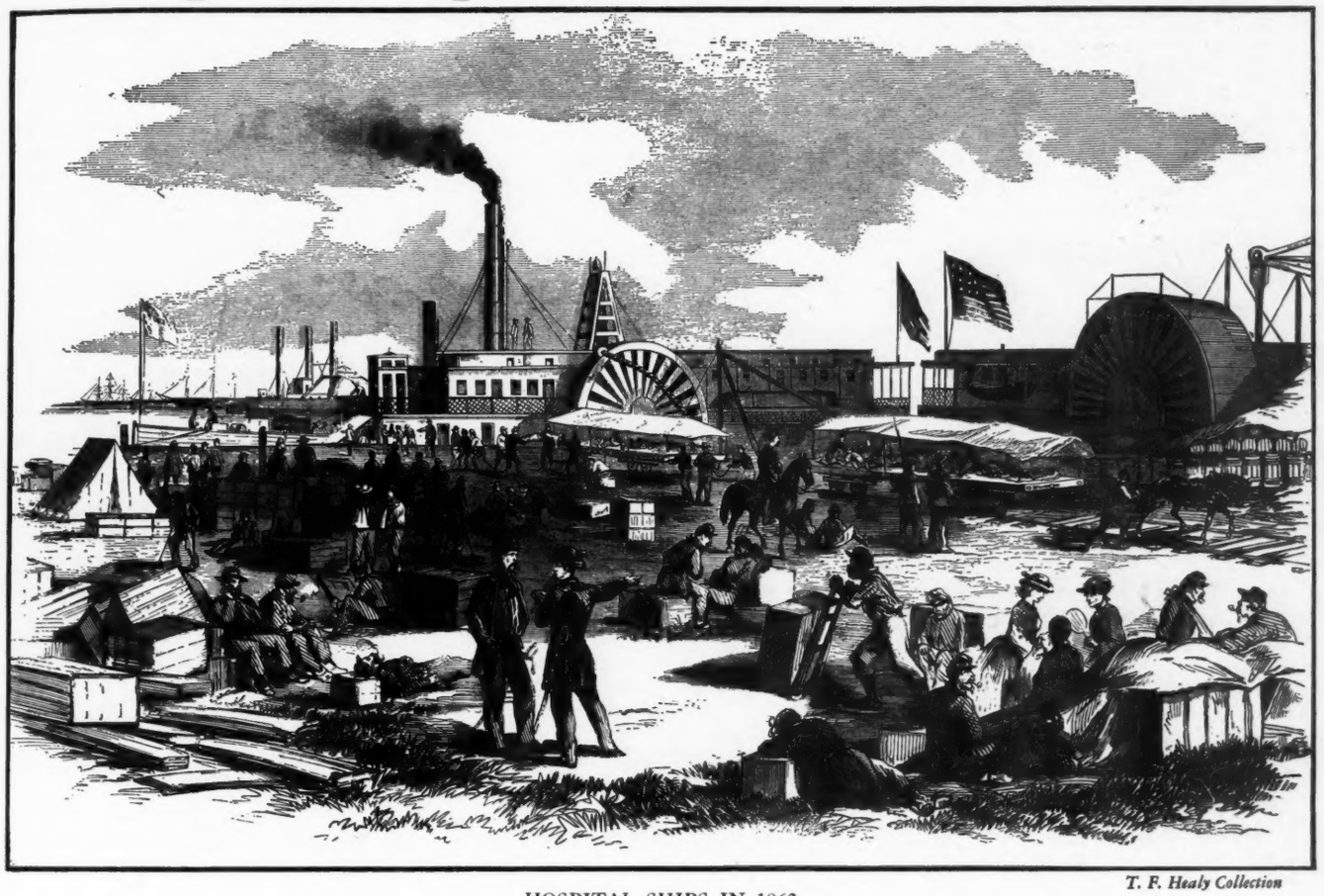
Two preconvention conferences have been announced by the Catholic Hospital Association, the conference on hospital administration, June 11 and 12, and the conference on nursing education, June 12 and 13, at Loyola University, Chicago. These are under the patronage of Cardinal Mundelein, archbishop of Chicago.

Doane to Repeat Refresher Course

The two-weeks' refresher course in hospital administration given by Cornell University last summer under the direction of Dr. Joseph C. Doane. editor, The MODERN HOSPITAL, and director, Jewish Hospital, Philadelphia, proved so successful that it is being repeated again this summer. The course is planned exclusively for hospital superintendents, medical directors, assistant superintendents, assistant medical directors, and selected department heads. The lectures given by Doctor Doane will cover the same topics as last year: organization, inventories, medical staff, dietary department, housekeeping department, maintenance, laundry, accounting and collections, nursing, rounds, trustees, ethics and intangibles.

As Fort Monroe Counted The Toll

Hospitals Depended on Webb's Alcohol



T. F. Healy Collection

HOSPITAL SHIPS IN 1862

Throngs gathered to watch the arrival of hospital ships at Fort Monroe, Virginia, in 1862. Amid tumultuous scenes, a part of the injured was immediately borne from boats to litters for transportation to land hospitals. Others, more severely injured, had their wounds dressed by surgeons on the quay as anxious groups of friends and relatives waited. Uppermost in their minds was the question, what would be the toll?

WHILE others faltered, heartsick before the mockeries of war, hospitals stood firm. Accepting all challenges with a magnificent disregard for the obstacles, they brought to sick and injured the unwavering hands needed to bind together shattered body and morale.

Every available force—on land and on water—was mustered in an effort to cope with the grave problems of hospitalization imposed by war. Of all the resources medicine could command, none rendered greater service than alcohol.

Antiseptic, preservative, an essential component in scores of tinctures, elixirs and infusions—alcohol was one material for which hospitals had no substitute.

By their sides, unfailing in any crisis, was the House of Webb keeping pace with each new demand. Staunch to its duty of supplying the purest alcohol—alcohol which never varied in quality—Webb had pursued its unremitting task since 1835.

Today, Webb is still in the vanguard of manufacturers of pure alcohol for hospitals. When Webb became a part of the U. S. Industrial Alcohol Co. in 1915, there were added limitless technical resources and one other great brand of pure alcohol, U.S.I.-U.S.P. Today hospitals use both with equal confidence. Guard your highest standards by specifying Webb's and U.S.I.-U.S.P. brands.

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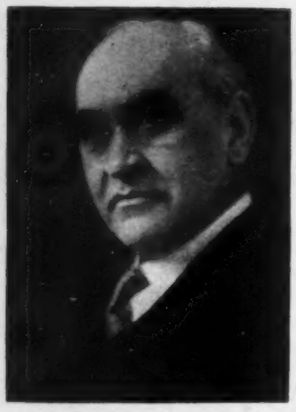
NAMES IN THE NEWS...

DR. WILLIAM ALANSON WHITE, for the last thirty-four years superintendent of St. Elizabeth's Hospital in Washington, D. C., died after a short illness. In addition to his hospital affiliation Doctor White had for many years been an outstanding authority on psychiatry and the treatment of mental



diseases. He was formerly a professor of nervous and mental diseases at Georgetown University school of medicine, clinical professor of neurology at George Washington University, and first lecturer on military psychiatry at the army and navy medical schools. Doctor White was the author of numerous books on neurology and psychiatry, and was editor, with Dr. Smith E. Jelliffe, of a series of monographs on nervous and mental diseases. He was also editor of the *Psychoanalytic Review*, and a member of the editorial board of The MODERN HOSPITAL.

DR. N. A. WILHELM, Boston, has been appointed superintendent of Butterworth Hospital, Grand Rapids, Mich., where he succeeds CHARLES E. FINDLAY.

AGNES HATCH, superintendent of De Kalb Public Hospital, De Kalb, Ill., has been appointed superintendent of Chillicothe Hospital, Chillicothe, Ohio, succeeding MRS. HARRIET FENZEL who is retiring after serving twenty-four years in that position.

MRS. BLANCHE M. COFFEE has been appointed superintendent of the newly completed Dos Palos Community Hospital, Dos Palos, Calif.

RUTH MILLER is the new superintendent at Cora Donnell Hospital, Prescott, Ark.

MAUD E. TRAVER, principal of the New Britain Hospital school of nursing, New Britain, Conn., resigned following the announcement of her betrothal to RICHARD H. DAVIS, a Chicago broker.

DR. CLAUDE W. MUNGER, superintendent of Grasslands Hospital, Valhalla, N. Y., for the last thirteen years, is to become superintendent of St. Luke's Hospital, New York City, on May 15. During Doctor Munger's administration Grasslands Hospital expanded from an institution of 350 beds to one of 795, with some additional wards for future use. Doctor Munger, who is a recognized authority on hospital construction and management, is president of the American Hospital Association and a member of the editorial board of The MODERN HOSPITAL. He will succeed the REV. GEORGE F. CLOVER.

DR. JOHN E. GORRELL, administrator of Falk Clinic, University of Pittsburgh, on April 1 becomes the new superintendent of Blodgett Memorial Hospital, Grand Rapids, Mich.

M. CORDELIA COWAN, educational director of the post graduate school of nursing of the Woman's Hospital, New York City, has been appointed executive secretary and treasurer of the Nurse Examining Board, Washington, D. C. She will be succeeded by ELLA M. RAFUSE.

DR. EDWARD M. BERNECKER has been appointed general medical superintendent in the New York City hospitals department. Doctor Bernecker replaces DR. ADAM EBERLE who was promoted to senior general medical superintendent and assigned to the department's main offices in Manhattan. Coincident with this change. DR. EMANUEL GIDDINGS, medical superintendent of Morrisania Hospital. was promoted to the same berth at Kings County Hospital. DR. HENRY GREENBERG, medical superintendent at Fordham Hospital, goes to Morrisania in place of Doctor Giddings. The Fordham post will be taken by DR. STEPHEN H. ACKERMAN, who was formerly medical superintendent at Coney Island Hospital. DR. C. G. MCGAFFIN is transferred to Coney Island Hospital.

DR. HERBERT C. WOOLEY was recently appointed superintendent of Pennhurst State School, Pennhurst, Pa.

DR. HILLIS L. SEAY, clinic physician at North Carolina Sanatorium, Sanatorium, has been appointed superintendent of Mecklenberg Sanatorium, Huntersville, N. C., to succeed DR. JOHN DONNELLY.

DR. A. C. KOLB, superintendent of State Hospital, Little Rock, Ark., has announced his resignation.

MRS. M. KAELBERER has been appointed superintendent of Memorial Methodist Hospital, Mattoon, Ill.

DR. SIMON TANNENBAUM, medical director of Sydenham Hospital, New York City, died following a heart attack. Doctor Tannenbaum was at one time assistant to DR. S. S. GOLDWATER, present New York Hospital Commissioner, then superintendent of Mt. Sinai Hospital. Later Doctor Tannenbaum served as superintendent of the Jewish Hospital in Philadelphia, subsequently returning to New York to become superintendent of Beth David Hospital. The past year he spent in Palestine serving as medical director of the Hadassah unit, devoting his time to organizing the hospital service.

MRS. DORA BECKMAN MILLER, superintendent of nurses at Sioux Valley Hospital, Sioux Falls, S. D., has been elected director of nurses at Grant Hospital, Chicago. She succeeds MARY WATSON, who is retiring.

FLORENCE H. PETERSON has been named superintendent of St. Luke's Hospital, Fergus Falls, Minn., succeeding ETHEL A. JONES who retired to go to China as a missionary.

MRS. FLORENCE C. SMITH, superintendent of Homeopathic Hospital, West Chester, Pa., has announced her retirement and her plan to live in California. She will be succeeded as superintendent by MARGARET P. FAITH, superintendent of nurses.

SISTER MARY HERMAN, formerly sister superior and superintendent of St. Joseph's Hospital, Lancaster, Pa., and last surviving founder of the hospital, died recently. She had been ill for several years preceding her death.

SARA J. CLARK, assistant superintendent of Annie M. Warner County Hospital, Gettysburg, Pa., has been appointed superintendent following the resignation of MARTHA MCKAY.

SISTER ALICE ELIZABETH has succeeded SISTER ROSE GENEVIEVE as superintendent of Pittsburgh Hospital, Pittsburgh.

HELEN OSTEN, superintendent of Marietta Hospital, Marietta, Ohio, has announced her resignation.

MRS. ADA R. CROCKER, executive secretary of the Illinois State Nurses Association, has accepted the position of director of the school of nursing of Cook County Hospital, Chicago, effective May 1. She succeeds EDNA S. NEWMAN. Mrs. Crocker was superintendent of nurses at St. Lukes Hospital, Chicago, before taking up her work with the state association.

MRS. R. H. MORGAN, Georgia Baptist Hospital, Atlanta, Ga., has been appointed head record librarian at Baptist Hospital, Birmingham, Ala.

DR. SAMUEL M. BITTINGER, assistant superintendent of the North Carolina Sanatorium for Treatment of Tuberculosis, Sanatorium, is to be director of the new Western North Carolina Sanatorium, Black Mountain.

Reenact Malpractice Suit for Western Association

Somewhat out of the ordinary run of hospital association conventions is the program of the Association of Western Hospitals which will meet in Los Angeles from April 12 to April 15, in conjunction with dietitians, record librarians, medical social workers and the nursing association. Only one talk will be given at a session with but one session scheduled in the morning and one in the afternoon.

A high spot in the meeting will be the dramatization of the case of Sokum *vs.* Memorial Hospital. The last day of the presentation of the defense will be reenacted under the leadership of Howard Burrell, Los Angeles attorney, with judge, attorneys, witnesses and a jury taking part. The play will be staged at 2:30 on Wednesday afternoon and will be followed by a round table discussion led by Mr. Burrell and the participating attorneys.

Among the speakers at the convention will be Dr. Benjamin W. Black, superintendent, Alameda County Hospital, Oakland; Manchester Boddy, editor, *Illustrated News and Evening News*, Los Angeles; Howard Burrell; Frank Van Dyk, executive director, Association of Hospital Service, New York City; C. Rufus Rorem, representative, American Hospital Association; Dr. Claude W. Munger, president, American Hospital Association; Dr. B. C. McLean, president, American College of Hospital Administrators, and Prof. Ordway Tead, lecturer on personnel administration, Columbia University.

Hahn Receives Letter From Roosevelt on Hospital Day

National Hospital Day will be twelve years old on May 12. In accordance with White House custom, President Roosevelt has issued the following proclamation:

March 2, 1937.

The White House,
Washington.

My dear Mr. Hahn:

On the occasion of National Hospital Day, I wish to take the opportunity to express my feelings in regard to the tremendous service which the hospitals of this country are rendering to the people of the Nation.

In this war which the medical and nursing professions are continually waging against sickness and injury, our hospitals are the great fortified centers from which the battle is carried on, and members of the American Hospital Association, through their work of improving and coordinating hospital services and organization, are performing a heavy part of the task of the alleviation of human suffering.

I am certain that a day such as National Hospital Day, set aside to draw the attention of our people to this great work, fills a wise and important purpose.

Very sincerely yours,
(Signed) Franklin D. Roosevelt.

Mr. Albert F. Hahn,
Chairman, National Hospital Day Committee,
Protestant Deaconess Hospital,
Evansville, Ind.

Texans Assemble for Two-Day Hospital Meeting

The annual two-day session of the Texas State Hospital Association will be called to order at Lubbock on Friday, April 23, by President Martha Roberson, superintendent, Medical and Surgical Hospital, San Antonio. Dora Mathis, John Sealy Hospital, Galveston, will open the formal program with a discussion of the new curriculum for schools of nursing, to be followed by a round table on nursing problems under the leadership of Robert Jolly, superintendent, Memorial Hospital, Houston.

A panel discussion on vacations, sick leave, salary and discounts, under the leadership of Dr. Lucius R. Wilson, superintendent, John Sealy Hospital, Galveston, is scheduled for early afternoon. Gertrude Lynch, Santa Rosa Hospital, San Antonio, is to talk on the preparation and serving of special diets. Bryce Twitty, superintendent, Baylor University Hospital, Dallas, will lead the closing round table of the afternoon.

The care of crippled children in Texas, as told by J. J. Brown, director, vocational rehabilitation and crippled children's division of Texas, will open the Saturday morning program. The Galveston State Psychopathic Hospital will be discussed by its superintendent, Dr. Giles Day; the qualifications and duties of a record librarian will be analyzed by Sister Mary of Jesus, St. Joseph's Hospital, Fort Worth, and Marie Luppolk, Methodist Hospital, Houston, will attempt to answer the question "Shall the hospitals have subsidiary workers?" A round table by Robert Jolly will close the morning session. The afternoon will be given over to association business.

Mayor Signs Bill for 8-Hour Day

An eight-hour day schedule will go into effect for nurses in New York City's hospitals on July 1, the result of a bill recently signed by Mayor La Guardia. It is thought to be the first time that an eight-hour day for nurses has been established by law. Many nurses attended the statutory hearing on the bill.

Sunday Collection Raises $10,525

Evanston, Ill., held its fortieth annual Hospital Sunday, recently, and collections reported by twenty-two churches and hundreds of individuals amounted to $10,525, 21 per cent over the total raised last year. Contributions not credited to churches amounted to $1,194 from Winnetka, Ill., and $1,374 from Evanston. According to Ada Belle McCleery, superintendent of Evanston Hospital, the money is used for support of the charity out-patient department as well as for making up the difference in hospital expense created by part-pay patients. The Roman Catholic churches postponed their collections one week in order not to interfere with a scheduled missionary collection, so that their contributions have not been announced at the time of going to press.

Iowa Announces Meeting Plans

A luncheon on Monday, April 26, will start the Iowa Hospital Association convention at Dubuque. Speakers scheduled for the three-day meeting include Robert E. Neff, director of the University of Iowa Hospitals, Dr. A. F. Branton, president of the Minnesota Hospital Association; Dr. Kate Daum, director of the nutrition department, University of Iowa Hospitals; Dr. William O'Brien, associate professor of pathology, University of Minnesota. Joint meetings with the Iowa Record Librarians, the Iowa Dietetic Association and the Iowa League of Nursing Education are scheduled. Dr. R. C. Buerki and A. R. Hardgrove will assist with round table discussions.

READER OPINION

Plans and Suggestions

Sirs:

Plans are being drawn to build a 100-bed addition to our hospital in 1938. I have marked and placed all of last year's copies of MODERN HOSPITAL in the hands of our building chairman and architect. There are many valuable plans and suggestions in them.

ADA I. LEONARD, R.N.
Superintendent.

Middletown Hospital,
Middletown, Ohio.

Confusion of Names

Sirs:

On page 124 of the March issue of The MODERN HOSPITAL there is a news item headed "Fire in Philadelphia Hospital." This states that the fire occurred in the D. Hayes Agnew Wing of the Graduate Hospital of the University of Pennsylvania. This is not correct. The fire occurred at the Hospital of the University of Pennsylvania and not at the Graduate Hospital.

This error has caused us some inconvenience, as we are being pestered with salesmen, literature, etc., from the makers of fire fighting devices and protective equipment.

DONALD C. SMELZER, M.D.
Director.

Graduate Hospital of the
University of Pennsylvania,
Philadelphia.

LITERATURE *in* ABSTRACT • • •

Conducted by E. M. Bluestone, M.D. and Joe R. Clemmons, M.D.

Organizing Dental Research

On September 13, 1932, at Buffalo, N. Y., Alfred Walker presented to the board of trustees and to the research committee of the American Dental Association a brief argument entitled "The Need for Comprehensive Research into the Cause of Dental Caries," pointing out that the American Dental Association had up to that time expended more than $300,000 for research, much of which concerned problems related to the cause of dental caries; that in addition to this other research in the same field had been carried on either with or without subsidy from interested persons or organizations and that the total expenditures in this country had reached a respectable figure.*

It was noted that much of the laboratory work had not been correlated and that also the clinical observations had not been carefully recorded and filed, and that in the main the total amount of clinical data and the laboratory evidence had not been assembled and correlated. No serious effort to collaborate for the purpose of seeking out common factors upon which to base an analysis that would lead to definite clues concerning immunity or susceptibility to dental caries was evident. It is with a view to organizing dental research that the following program is suggested.

1. Establishment of a central bureau for organizing research. The central plant should consist of a small series of rooms in a central locality where accessories such as libraries, dental laboratories and supply houses are available. The plant should have an office for the director of research which could also be used for such meetings of committees and trustees of research as are held. Connected with this office should be a library and a repository which could be expanded as demands arise.

There should be a private laboratory for the use of the director, in which he could carry on his personal research and such additional investigation as might be required. The library should be built up by donations of books, preferably dental journals in sets and reprints of publications on dental research.

2. Appointment of a director. It is recommended that the regulations of the National Research Council for subsidizing research be adopted for dental research.

3. The setting up of a small group of members of the association to act as advisers to the director, these men being known as trustees of research.

4. The setting up of a central library and repository where information may be had by investigators and where they may obtain advice concerning their problems, library facilities, models of apparatus, special operations and demonstrations of methods similar to the central bureau of the American College of Surgeons, Chicago.

There would be personal research for which adequate laboratory facilities would have to be provided and the service of an assistant director or curator as custodian of library and repository materials. Research in the field of repair and cure, and in prevention are necessary.

5. Provision for a board of advisers from the basic sciences, not necessarily dentists but men of unquestioned status in their several lines capable of aiding the director in allocating funds for research.

*Morse, Withrow, and Walker, Alfred: A Definite Plan for Dental Research, J. A. D. A. and Dental Cosmos, Jan., 1937. Abstracted by David Tanchester.

Favorite Desserts

Observations were made as to the frequency of sales of 25 desserts in 56 eating places.* Apple pie proved to be the most popular dessert while ice cream rated second. Other popular desserts are: apple strudel, blueberry pie, Boston cream pie, chocolate layer cake, coconut custard pie, devil's food cake, home made cake, lemon chiffon pie, French pastry and rice pudding.

*What America Is Eating, Hotel Manage., Nov., 1936. Abstracted by Marie Ryan.

Tuberculosis Ratio Among Nurses

In a comprehensive study* based partly on his own experiences and partly on pertinent citations from the literature, the author attempts to answer the question: "What are the chances of a nurse becoming infected when caring for tuberculous patients?"

At the outset these facts are stressed:—(1) the tuberculin positive nurse is less likely to become infected as a result of contact with tuberculous patients than is the nurse who is tuberculin negative; (2) the possibility of infection increases with the length of contact or exposure; (3) young women from communities with a low incidence of tuberculin positive reactors are particularly apt to encounter tuberculosis in hospitals for the first time and as a result many of them become infected and some fall prey to the disease; (4) the incidence of infection, surprisingly enough, varies considerably even in tuberculosis institutions.

The enrollment of a large proportion of tuberculin negative student nurses presents a problem which was not in existence a few decades ago when practically every young adult was infected. Knowing that a certain percentage, even though it is small, of those who are infected will eventually develop tuberculosis, the author believes it a good plan to employ only tuberculin positive nurses.

In this he is supported by many other authorities as well as by Heimbeck, whose experiences may be cited. The latter found that among 1,200 nurses, 48 per cent were tuberculin positive when they entered training and 52 per cent were tuberculin negative. Subsequent examinations revealed that of the tuberculin positive group, 24 or 4.2 per cent developed some type of tuberculosis. There were no deaths in this group. On the other hand, of the first 275 tuberculin negative matriculants, 97 or 35.2 per cent died.

As a result, Heimbeck vaccinated the remaining 355 tuberculin negative nurses with B.C.G. Of the group that remained tuberculin negative, after the vaccination, 23.5 per cent developed some type of tuberculosis and 12.5 per cent of them died. But of the ones who became tuberculin positive following the vaccination, only 1.9 per cent developed tuberculosis and there were no deaths in this group.

In his own study of a large group of nurses, the author found that adult forms of tuberculosis develop more frequently in nurses who were tuberculin negative at the beginning of their training. Granting the high incidence of disease in females of this age group, nevertheless tuberculosis in nurses is a distinct occupational hazard and calls for serious study with regard to methods of prevention of infection.

The author lists in detail the instructions which nurses at the Glen Lake Sanatorium, Oak Terrace, Minn., receive. Briefly, these instructions pertain to the teaching of patients to cover their mouths with paper napkins when coughing or sneezing and the proper disposal of such napkins as well as other excreta; the provision of clean gowns for the nurses; leisure periods; periodic x-ray examination of nurses at the beginning of employment and every three months subsequently, and the limitation of employment, whenever possible, to nurses who are positive tuberculin reactors.

*Mariette, Ernest S.: The Tuberculosis Problem Among Nurses in a Tuberculosis Sanatorium. Tubercle, 18: 103 (Dec.) 1936. Abstracted by Eli H. Rubin, M.D.

Air Conditioning for Hay Fever

Up to 4,000,000 persons in the United States suffer from hay fever. Increased exposure to pollen due to automobile transportation has increased the number in the past decade.*

East of the Rocky Mountains ragweed pollens are responsible for 85 per cent of autumnal hay fever. In Pacific and Rocky Mountain states wormwoods are the causative factor. Grass, plant and tree pollens produce similar effects. However, the pollenating season is short and they create little disturbance.

These symptoms appear in an individual sensitized to pollen protein: running nose, watery and itching eyes, attending symptoms typical of head colds. Medical treatment attempts to desensitize an individual by injecting increasing amounts of pollen protein about two months before the hay fever season. Desensitization is transient and must be repeated.

Studies were conducted on the effect of filtration of air in the relief of hay fever and pollen asthma. By use of a centrifugal blower having a flexible connection to a filter form to eliminate mechanical vibration, air was propelled at slow speed through an inexpensive, large area, cellulose filter into a ward to produce a slightly positive pressure. The filters were changed frequently. Comparative pollen counts showed 98 to 99 per cent removal of pollen from the filtered air.

One hundred and seventeen patients with positive skin tests for ragweed pollen were studied for an aggregate of 483 nights. These patients were relieved completely, or almost completely, of all symptoms in one-half to one and one-half hours' confinement in pollenfree air and continued symptomfree as long as they remained.

Pollen asthma ultimately develops in 15 to 40 per cent of cases of hay fever and is accompanied by changes in the lungs. Longer confinement in filtered air is required for relief of symptoms. Forty-seven cases were studied. From one and a half to five days' confinement produced relief of symptoms in most cases. A few were unrelieved. The efficiency of pollen removal to give relief is dependent upon the degree of sensitivity of the individual.

Hay fever and pollen asthmatics were less comfortable in a cool room with high relative humidity than in rooms with higher temperature and lower relative humidity.

An eight-bed ward was run at a temperature of 80° F., relative humidity 30 per cent, to study effects of low humidity on pollen asthmatics. During a thunder storm all patients in a ward where the humidity was not controlled had asthmatic seizures. The seizures could not be attributed to pollen. An experiment was conducted to see whether these seizures would occur where the relative humidity was maintained at a constant point. Ozone was introduced into the air of the ward in quantities larger than occur during electrical storms without producing any effects. Negative ionization of the air produced no effects. Asthmatic seizures did occur in controlled humidity. The onset was delayed, the attacks not as severe and recovery more rapid. The reason for the onset of these attacks in a pollenfree atmosphere obviously is not increased relative humidity but remains undetermined.

The filtration of the air in such fashion as to remove a major portion of the pollen is the important factor for relief of symptoms in hay fever and pollen asthma. Cooling with dehydration offers additional comfort.

Where air filtration is to be used as a relief measure be certain that pollen is the causative factor.

The following are important features in the purchase of an air filtration machine: (1) the area of the filter material should be relatively large; (2) there should be no appreciable vibration in the apparatus; (3) the volume of air delivered for a given unit of time must be sufficient for comfort.

The public can secure information as to the efficiency of most of the air filtration machines for relief of hay fever from the laboratory of the council on physical therapy of the American Medical Association.

It is suggested that efficient air filtration, with recirculation and filtration, may be applicable to allergic manifestations from antigenic dusts. Concentration of these environmental dusts could be reduced so that there would be little danger of producing sensitivities in individuals and so that they would probably produce no allergic manifestations in those already sensitized.

*Welker, William H.: Air Conditioning and Its Effect on Hay Fever and Pollen Asthma. Heat. and Ventil. 33: 35 (Nov.) 1936. Abstracted by J. R. Clemmons, M.D.

Compensation Without Rehabilitation

The present study by an assistant in the rehabilitation division of the New York State Education Department represents an analysis of 322 final adjustments in nonscheduled wards in workmen's compensation (compromise agreements).* There have been varied conflicting and selfish interests in the litigation of these problem cases and a rational approach to an evaluation of the therapeutic results is attempted. Do these men recover? Do they return to work? Do they become public charges?

One of the most difficult problems in the administration of workmen's compensation has been the practice of commuting compensation to one or more lump sum payments to injured workers, in the interests of justice. The basic principle involved in workmen's compensation is that payment be made in lieu of wages during a period of disability. Unless an investigation clearly establishes the fact that an injustice would be done a claimant if his compensation were not commuted to a lump sum payment, a lump sum should not be granted.

Among the many reasons favoring the growth of the practice of granting lump sum payments are (1) failure to recognize the fundamental distinction between workmen's compensation and other forms of insurance; (2) expediting of administrative difficulties; (3) therapeutic efficaciousness from medical point of view; (4) immediate payment of legal fees; (5) availability of money for commercial investments; (6) political favors. It cannot be expected that the industrial class of people, unaccustomed to handling large sums of money, will in every instance be prudent and wise in the utilization of large sums of money. Careful guidance and supervision of the investments by injured workers are necessary to protect the welfare of the incapacitated employees and their dependents after the granting of lump sum compensation.

As a result of this study, it seems the most intelligent method of administering the present system is to demand a close and effective cooperation between compensation and rehabilitation agencies. In effect, the rehabilitation division agent serves as guardian and trustee of funds granted as lump sum compensation to ensure the most effective reconstruction of the worker's life. Basically, workmen's compensation without a vocational rehabilitation service is an unfinished government responsibility.

The successful management of lump sum settlement cases resulted in an attempt to extend this function of the rehabilitation service to so-called compromise settlements in nonscheduled disability awards. Unfortunately, however, the disadvantageous lack of control over this group of employees by the rehabilitation worker has handicapped the supervision, so that it has not been unusual for the injured employee and his family to become public charges ultimately. The primary objective of workmen's compensation should be the reconstruction and rehabilitation of the employee; the monetary and legal exigencies should not overshadow the welfare of the claimant.

The real cost of industrial accidents in New York State each year is probably about 120 million dollars, a figure which should of itself commend the subject of compensation administration to all concerned. The compromise cases have proved to be about ten times as

Sleep and rest are important measures of therapy. The hospital provides comfortable beds and silence at night to promote undisturbed sleep. But if sleep does not come—physicians have for years relied on Medinal to open the portal to the Land of Nod.

Medinal is the Schering & Glatz brand of soluble barbital. It is available in tablets and powder, both forms suitable for oral, hypodermic or rectal use. That means that you need but one stock of this efficient hypnotic and sedative. The Hospital Package of 500 tablets is priced at $6.50. For palatable liquid medication, Elixir Medinal costs but $9.00 a gallon to hospitals. Orders must be sent to us direct . . . These special low prices permit no discount to distributors.

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costly as the usual time-lost injuries, the average settlement being $3,700. In each case complications arising involve determination of the extent of injury, establishment of causal relationships, conflicting expert medical testimony, questionable future earning capacity and an evaluation of the consequences of the mental attitude of the claimant.

Former Commissioner Perkins recognized the advantages of securing the services of practical specialists in occupational guidance of the rehabilitation division and so instructed the referees. The burden of proof has always been on the part of the rehabilitation worker and the assumption by the labor department that the claimant can take proper care of his money is not always warranted. In cases where advance awards or compromise settlements were granted, the lack of other than voluntary control by the rehabilitation case workers has been a serious handicap. Too infrequently does the settlement money play a part in rehabilitating the claimant so as to establish a future livelihood.

The much mooted claim of therapeutic benefit from lump sum settlement in compensation neuroses finds little factual support in this series of cases. Less than one quarter of the cases showed improvement when re-investigated. There is general agreement by medical men that curtailment of litigation is a desideratum in the management of compensation claimants. Neurotic conditions are fostered by the "law's delay." Many causes contribute to the tardy adjudication and the neurosis may become well grounded and be unaffected by the indemnity payment. Early closures are imperative, but the settlement should not be of the lump sum type except in rare cases. The author believes that compromise cases should receive the final settlement amount on deposit, with bi-weekly withdrawals and advance awards subject to the approval of a rehabilitation worker.

*Noreross, Carl: Vocational Rehabilitation and Workmen's Compensation, 1936 Rehabilitation Clinic, New York City. Abstracted by J. Masur, M.D.

Radiology and the Practice of Medicine

The concept that a hospital ought not to practice medicine seems to have been violated insofar as the practice of radiology is concerned.* The nature of the equipment confines this medical specialty to office and hospital. The roentgen economies effected by hospital operation are in some measure possible because of charitable funds and these were never intended for the reduction of fees to private patients. Similar economies achieved by low salaries to radiologists are not conducive to good practice.

Unfortunately, in many instances the hospital management offers for sale the services of the staff roentgenologist and in so doing enters into direct and occasionally unethical competition. Organized radiologists demand that hospitals confine themselves to hospitalization and permit the practice of medicine to remain with licensed practitioners.

The solution suggested is an elaboration of the x-ray lease plan which has been much discussed recently and was the center of considerable interest in the round table conference at the administration section of this year's convention of the American College of Surgeons. The lease plan advocates the renting of space alone, or space and equipment, taking into consideration local office rentals, interest on capital investment, equipment depreciation and employment of technical help and use of supplies. An alternative scheme involves the payment of rent on a specific charge per examination, calculated by total charges in relation to total examinations. Patients are billed directly by the radiologist. Free work entails the defraying of basic costs by the hospital and the contribution by the radiologist of his services.

It is claimed that such a plan would (a) establish a more equitable and ethical relationship between hospital and radiologists; (b) remove questions of competitive corporate practice of medicine and division of fees; (c) increase hospital business and raise standards of x-ray practice in the hospital, and (d) eliminate hospital liability in the x-ray department.

A list of six hospitals using such a contract with radiologists is given. It is claimed that the rental plan offers the only permanent and satisfactory solution to the problem of hospital radiologic work.

*Editorial: The X-ray Department: A Solution for Hospital Administrators and Radiologists, Radiology, 27: 749 (Dec.) 1936. Abstracted by J. Masur, M.D.

The State and the Needy Sick

Public responsibility for the care of the needy sick is at present a topic of considerable discussion.* In the program now in effect in Rochester, a practical coordination of the available facilities attempts to meet the medical requirements of the community's indigent families. The plan arose through the increase in the number of dependent sick and the inadequacy of voluntary agencies to cope with the increased load. The laws of New York clearly establish the principle that the state has a definite obligation to provide medical care to those in need.

The growing deficits of private hospitals necessitated an arrangement whereby reimbursement by state subsidy was granted for clinic care of public welfare clients. This particular problem of dispensary care was combined under a single administration with provisions for home care, office care, hospitalization, custodial care, dental treatment and furnishing of medicines and medical appliances. The public welfare law does not provide for payment to private physicians for home and office care.

For the first time financial responsibility was assumed by the Department of Public Welfare for the clinic care of families on relief rolls. In each of five clinics a unit composed of a medical social worker and clerical aids was established with a close check-up on the status of all applicants. A fee of fifty cents is paid by the department for each visit. All medication costing the clinic less than fifty cents is supplied without additional charge. Expensive drugs, x-ray examinations and other medical needs are separately authorized. Venereal cases are not included in this set-up.

The amount paid to the hospitals for this service to welfare clients over the period from July, 1935, to January, 1936, was $37,174.82, approximately one-half of the combined hospital deficits of the previous year. Reimbursement is obtained for expensive medicines and medical supplies in accordance with regulations of the temporary relief administration.

There is a growing sense of public responsibility for the medical care of dependent families. Local funds are inadequate to meet the problem satisfactorily and the state must continue sharing the obligation.

*Applebaum, S. J.: Medical and Hospital Care for Dependent Families, J. A. M. A. 107: 1565 (Nov. 7) 1936. Abstracted by J. Masur, M.D.

Occupational Therapy for the Aged

This is a description of the program of a typical institution for the aged in which many interests and self-directed activities are present without benefit of an occupational therapist.* The largest activity is needle work and fancy work with gifts for relatives and friends and production for the annual Christmas sale. Some members are happiest when allowed to help in the special kitchen work. The value to the morale of the aged when granted the opportunity to be of real service is great, and even the kitchen may be utilized as an occupational therapy site. Gardening, special interests and the assignment of specific small duties serve to maintain reasonable activity with small responsibilities. Patriotic celebrations, holidays, and movies vary life in the home.

*Hutchison, Leon J.: Occupational Therapy at the Woman's Relief Corps Home, Social Welfare Bull. 7: 9 (Sept.) 1936. Abstracted by J. Masur, M.D.

BOOKS ON REVIEW

ON THE INCIDENCE OF ANAESTHETIC COMPLICATIONS AND THEIR RELATION TO BASAL NARCOSIS. *By C. J. M. Dawkins, M.A., M.D., B.Chir., D.A. London, England: John Murray.* 1936. *pp.* 56. *Three shilling and six pence.*

The phenomenal increase in the use of basal narcotics in the last few years has been largely due to the popular demand and enthusiasm for drugs which would eliminate to a great extent the unpleasantness and fear surrounding a surgical operation. Surgeons and anesthetists have had sufficient opportunity to study the risks involved and to make a fair appraisal of the advantages and disadvantages of the use of these drugs.

Doctor Dawkins after studying two apparently comparable series of figures (several thousand cases) relative to the incidence of anesthetic complications and their relation to basal narcosis, arrives at the following conclusion: "It has thus been shown that during the last five years definite progress towards the reduction of anesthetic complications has been made. This progress would have been still greater but for the injudicious use of basal narcosis."

Those who believe that a combination of several drugs in anesthesia is harmful are supported by Doctor Dawkins, whose views are well confirmed by figures.

The book is valuable in that it will encourage further studies of present practice and results, in an attempt to make certain that safety is not being sacrificed for comfort.—G. L. F.

DIETETICS. *By Alida Frances Pattee. Mount Vernon, N. Y.: A. F. Pattee, Twentieth edition.* 1936. *pp.* 868. $3.

This text might well be recommended by doctors, nurses, nutritionists and dietetic instructors. Publishers also should be pleased by an author energetic enough to rewrite her entire work, enlarging it, keeping it up to date, and making adjustments to meet the demands of the buyers.

This book is a paragon of its type for several reasons.

First, the work is complete and not "sketchy." It is recommended to the young teacher for classwork. The details, so far as class instruction is concerned, are carefully planned and systematically worked out so that the instructor is not apt to skip any topic which might stump the student in either examinations or practical application. Too often the overburdened young instructor is not fully prepared to face the class.

Second, the book is easy to read because of its clear type, spacing and simple outlines. The outlines are incorporated in each chapter and the material arranged so that the average student may readily have a mental picture of the material treated. Mental pictures are impressive and lasting and convert the material into classified knowledge.

Third, the recipes included in the chapters dealing with the matter at hand are dependable and are not annexed material. This is an especially good feature as the time element in seeking such information is reduced.

Fourth, the questions at the end of the chapters are excellent and sufficient in number to be of real assistance to the student preparing for reviews.

Fifth, the author has sought the able assistance of the leaders in the nutritional and medical world for authentic and up-to-the-minute information.

This twentieth edition should be an inspiration to those venturing to write texts. It is one of the most practical books available to date.—MARY EDNA GOLDER.

NEW PRODUCTS • • •

The Airy Tread

Walking on air becomes a reality when you walk on the new Airpath rubber tile of Paul Coste, Inc., Providence, R. I. How so? Because it is constructed of a sheet of hard surface rubber which is vulcanized to a sheet of sponge rubber. The result, the manufacturers state, is a perfect noiseless, soft walk-way. With its resistance to abrasion and fireproof quality, Paul Coste, Inc., feel that they have an ideal floor covering for any type of interior where quiet, comfort and long wear are prime requisites—which they certainly are in hospitals. It is available in sheets up to 42 inches wide; in lengths up to 27 feet.

Flexibility in New Bed

Acrobatic, that's what it is—this new bed, prosaically called Bed No. 16165, recently marketed by Simmons Company, 222 North Bank Drive, Chicago. The acrobatics, which means that it can be maneuvered into Fowler, Trendelenburg and reverse Trendelenburg positions, are made possible by what is known as the SRBY bottom operated by a removable crank on the foot end. This flexibility is, the makers opine, convenient in spinal anesthesia and shock cases. Both ends, head and foot, are equipped with a wire mattress retainer which keeps the mattress from slipping when tilted in extreme positions.

Also built on to the bed is a Decker lamp which has a long telescoping elbowed arm to which is attached a goose neck, connecting the lamp with the telescoping arm, making it possible to have a convenient light for abdominal examinations. When not used for examinations, this lamp, with the exception of the goose neck, may be used as a reading light for the patient, as a direct or indirect light.

As a means of preventing the wear and tear to which the foot of a bed is usually subjected, a white metal baffle plate has been built on to the top of the arch of the top crosspiece, which covers practically the entire top surface.

In addition to these novel attachments, the bed is equipped with 5¾-inch diameter wheel ball bearing rubber tired casters as well as foot brakes designed to permit satisfactory control of both ends of the bed from one end.

Easy Come—Easy Go

Getting needles down to a fine point is the special business of Becton, Dickinson & Co., Rutherford, N. J. They keep making them finer and finer and now comes a new rustless hypodermic needle, with, they assure us, a new and better point which enters with much less cutting and more dilation. These needles are conveniently packed by two's on metal cards, six cards to a box, or, in the larger sizes, a dozen to a single metal card. An added convenience is the B-D needle sterilizer tray which holds a dozen needles. This is an efficient, economical means of protecting needles from injury during sterilization.

What Is Plumbing Without a Valve?

The American passion for perfect plumbing is nowhere so much in evidence as in hospitals. One of the latest contributions of plumbing manufacturers to hospitals is the R-45-E valve for exposed piping, made by Leonard-Rooke Co., Inc., Cranston, R. I. This thermostatic water

mixing valve can be used on all types of installations, such as line control, batteries of showers and batteries of bathing tubs. It is so constructed that all servicing is done from the front. There are no packings to replace and only one moving part. Check valves and volume control and shut-off valve are required and they also may be obtained from Leonard-Rooke.

Another member of the same family is R-5-E, a thermostatically controlled mixing valve for surgeons' wash-up sinks, which comes complete with fittings and piping for the trifling sum of $65.

Whose X-Ray Is This?

That there shall be "no shadow of doubt whatever" as to the proper identity of your radiographs, Eastman Kodak Company, Rochester, N. Y., presents a new device to make the procedure of identifying radiographs more effective and time-saving. The method is photographic. The apparatus consists of a printer, housing an electric lamp, which makes an exposure on the x-ray film. The data are typed on an x-ray department requisition form. A corner of the film is shielded from radiation during the exposure to the x-rays. Then, this corner and the requisition form are placed in the printer to record the data on the film. It may be installed on any bench or table in the processing room. It plugs in to the regular electric supply circuit and is operated by a foot treadle.

Canned Heat Keeps Hot

Probably one of the best ways in the world to ruin a patient's disposition is to serve him food which has been allowed to grow cold and soggy, so if you have sadistic tendencies and enjoy ruining people's dispositions, don't read this, because it purports to tell you how to prevent that very thing.

The solution was suggested to us by the Sterno Corporation, 9 East Thirty-seventh Street, New York City, who manufacture a food carrier which is said really to keep hot food hot. Each of these portable food carriers, made of aluminum, stainless steel or tin, contains a can of Sterno canned heat which is the secret of the whole thing. It is necessary only to place the food in the carrier, open the Sterno can and touch a match to the canned heat. In two minutes the carrier reaches proper heat and will retain the same even temperature for as long as an hour. It is, says Sterno, like rolling the diet kitchen to the patient's door. There are two sizes: the individual and the Servitor which is large enough to hold four man-sized meals.

Paging New Literature

Safer Sterilization of Solutions — A short article on sterilization of media and solutions has been printed in pamphlet form entitled "Some Features Relating to Pressure Steam Sterilization of Media and Solutions of Particular Interest to the Laboratory Technician." This is a technical but understandable discussion of various sterilization failures which have necessitated test analysis, by W. B. Underwood of the American Sterilizer Company, Erie, Pa. It is available on request.

Service, Readymade—If your surgeons are going to leave sponges inside their customers, insist on their using ready-made ones—they're less expensive. Time was when ready-made bandages and dressings were not even thought of in hospitals—or if they were, it was with disfavor. Today, nurses who are spared the tedious task of cutting and rolling bandages and winding applicators can thank such

I know how you can make MORE MONEY!

A FRIEND of mine who runs a restaurant tells me that his biggest ghost is variable produce prices and unknown profits.

For instance, take lima beans. At this time of the year it is difficult to find lima beans of good quality on the market—yields of shelled beans are uncertain—their price varies up and down every day in the week.

My answer to all this grief is Birds Eye Lima Beans.

Here's why . . . First, Birds Eye Limas are FARM-FRESH—in season or out! They reach you today as tender and flavorsome as the hour they were picked. Then, Birds Eye Lima Beans come shelled, cleaned, ready for the pot. No pods to pay for. No labor taken up in the shelling. They're convenient to prepare and serve. Freshness and flavor are sealed in by the patented process of quick-freezing used for all Birds Eye Foods.

There is an exact weight of shelled limas in every package. You always know how many servings you get. With stabilized costs through the year, accurate raw material costs can be figured weeks in advance.

There are several types of Birds Eye Lima Beans available—all of the same selected quality—at definite prices to fit every size food budget.

Let me send you a booklet we just wrote that gives you a dozen new recipes for serving Lima Beans. Recipes that bring you menu variety and honest to goodness profits. Write me at Frosted Foods Sales Corporation, 250 Park Avenue, New York City.

Edwin T. Gibson

EDWIN T. GIBSON
PRESIDENT

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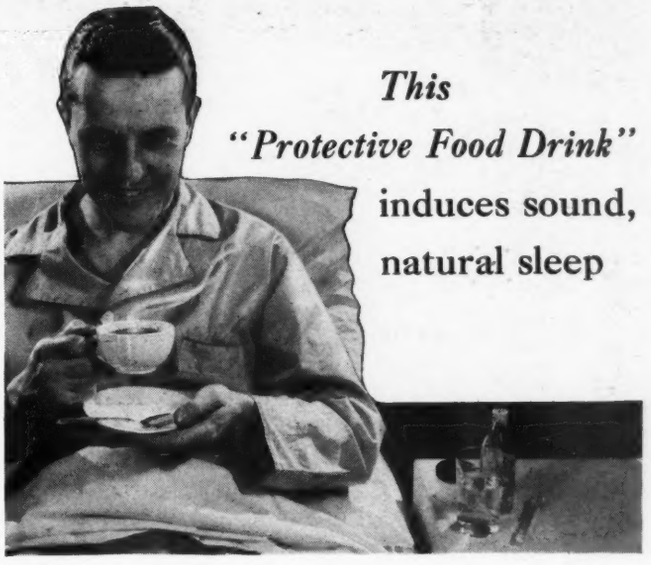

This "Protective Food Drink" induces sound, natural sleep

THERE ARE two reasons why a night-cap of Cocomalt, the protective food drink, helps to promote sound, refreshing sleep: **1.** Taken hot it helps draw the blood from the head. **2.** While it is distinctly a "food" it imposes no digestive strain.

Dietetically, Cocomalt provides highly desirable food essentials in a particularly tempting and delicious form. Because Cocomalt is a food, not a medicine, it can be safely used by young and old alike—from children to adults of advanced age.

Each serving of Cocomalt in milk provides .33 gram of Calcium, .26 gram of Phosphorus, 5 milligrams of Iron in readily assimilated form and 81 U.S.P. units of Vitamin D. Cocomalt is sold at drug and grocery stores in ½-lb. and 1-lb. purity-sealed cans. Also, for professional use, in 5-lb. cans available at a special price.

Cocomalt is the registered trade-mark of R. B. Davis Co., Hoboken, N. J.

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houses as Johnson & Johnson, New Brunswick, N. J., who specialize in readymade dressings for relieving them of the burden. The new Johnson & Johnson Hospital Service Book and Catalog No. 3 contains descriptions and illustrations of their principle items and much valuable information and advice on ways of making the best use of them.

Promoters of Cleanliness—"The Scope of Sanitation" undoubtedly isn't as wide as it should be, but that certainly isn't the fault of the West Disinfecting Company, Long Island City, N. Y., who have recently published a booklet under that title. This brochure offers and illustrates disinfectants, cleaners, liquid soap (complete with dispenser) paper towels, insecticides and numerous other products designed for the promotion of sanitation—to combat the spread of disease, destroy insect pests and maintain cleanliness.

The proper maintenance of floors is another concern of West Disinfecting Company and an informative handbook on the subject is available to seekers after knowledge.

Interior Decoration Note—The beautification of the operating room takes another step forward with the advent of the new "Sterile Brite" surgical furniture, wheel stretchers, dressing carts, operator's stools, solution stands, designed and manufactured by Scanlan-Morris Company, Madison, Wis. Frames are of continuous heavy tubular steel, finished in chromium plate said to be highly resistant to stains, scuffs, scratches or the effects of antiseptics used in the operating room. The tubular members are joined by streamlined bronze connectors. Tops and shelves are of laminated constructon with a layer of sound deadening material between the metal to eliminate resonance when articles are placed or dropped (particularly dropped) thereon. Silencing accessories, quiet moving rubber-tired wheels and solid rubber casters, says Scanlan-Morris in the literature describing the furniture, meet the modern demand for noise reduction in operating rooms and surgical wards. Definitely, the superintendent with the yen and the price to modernize his operating room would be interested in seeing the above-mentioned literature.

Long Live the Furniture—When they say Life Long—they mean lifelong, firmly announces the Hard Manufacturing Company, Buffalo, N. Y., in its new catalogue of "Life Long" metal furniture. They don't say whose life. A complete line of metal furniture for hospitals and institutions is extolled in this booklet, with illustrations and succinct descriptions of individual items. Matched sets for room groups may be had with the same shade of finish, or the same wood graining, for every piece, which, they feel, gives added charm and distinction to a room. And so it does.

New Beauty Treatment for Walls—With simple dignity the Clopay Corporation, York, McLean and Exeter Streets, Cincinnati, announce the arrival of Duray, a new washable wall covering in two words: "It's here!" The advantages of Duray, said to be washable with soap and water, and stainless to ink, grease, butter and ashes, are set forth in a snappy, ultramodern catalogue which contains graphic illustrations and swatches of the material. The process of manufacture is explained for the benefit of those who like to know just what they are buying. Clopay Corporation will undoubtedly be pleased to send a copy of the catalogue.

Correction.—The excellent laboratory catalogue noted in this column last month and attributed to Sharp & Smith, 65 East Lake Street, Chicago, should have read: Sharp & Smith, Hospital Division of A. S. Aloe Company, 1813 Olive Street, St. Louis. We regret the error and hope that inquiries regarding the catalogue will reach their proper destination.